



Request for R&C Estimate for American Express

Patient Name: _____

Patient Identification Number: _____

Provider Name and Address: _____

Provider Phone Number: _____

Procedure Code: _____

Code Component (professional, rental, purchase, etc.): _____

Diagnosis Code: _____

Provider's Fee: _____

Date of Service: _____

*** Please have your provider complete the above form in full and fax to 1-845-695-4340, Attn: Kristen Brennan; R8915. Be advised that the information given in response to this form is only to be used as an out of pocket cost estimate. It is not a guarantee of payment nor is it a verification of medical necessity. Reasonable and customary rates are subject to periodic review and update.**