Administered by

Providence Health Plan | Providence Health Plan

Member Reimbursement Form for Medical Claims

ONE FORM PER PATIENT PER PROVIDER

Please print clearly, complete all applicable fields and sign. Retain a copy for personal records as your information will not be returned to you. Proof of Payment is required. Please submit all documents to:

Providence Health Plans, Attn: Claims Processing, P.O. Box 3125, Portland, OR 97208-3125
Fax: 503-574-5940

1. PATIENT'S NAME (LAST, FIRST, MIDDLE)

2. PATIENT'S MEMBER ID #

3. INSURED'S GROUP #

4. PATIENT'S ADDRESS

5. PATIENT'S PHONE #

6. PATIENT'S DATE OF BIRTH

If payment should be made to a covered family member, custodial parent, or legal guardian instead of the subscriber/policyholder of the health plan, please complete fields 7 – 9. **Payment and explanation of benefit will be sent to the subscriber/policyholder unless an alternate payee is indicated in fields 7 – 9.**

7. PAYEE NAME

8. PAYEE ADDRESS

9. PAYEE PHONE #

The following information must be obtained from your provider. If you have an itemized statement or bill from your provider, you may provide a *copy* of it instead of completing fields 10 - 18.

10. DATES OF SERVICE	11. PLACE OF SERVICE (OFFICE, TELEHEALTH, URGENT/ER, HOSPITAL, PHARMACY, HOME, ETC.)	12. DIAGNOSIS CODES (ICD-10 CODES REQUIRED)	13. PROCEDURE CODES	14. AMOUNT CHARGED	15. AMOUNT PAID

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16. PROVIDER'S NAME

17. PROVIDER'S TAX ID #

18. PROVIDER'S BILLING ADDRESS

19. IF PATIENT IS COVERED BY ANOTHER INSURANCE PLAN, PLEASE PROVIDE THE INSURANCE COMPANY'S NAME

If other insurance made a payment for these services, please include a *copy* of the Explanation of Benefits.

20. IS THIS RELATED TO THE PATIENT'S EMPLOYMENT?

- ☐ No
- ☐ Yes — DATE OF INCIDENT: ____/____/_____

21. IS THIS RELATED TO AN AUTO ACCIDENT?

- ☐ No
- ☐ Yes — DATE OF INCIDENT: ____/____/_____

22. FOREIGN CLAIMS - FOR SERVICES OUT OF THE UNITED STATES, PLEASE EXPLAIN THE PLACE OF SERVICE (OFFICE, HOSPITAL, URGENT/ER, PHARMACY, ETC.), AND EXPLAIN THE NATURE OF THE INJURY OR ILLNESS:

23. PLEASE ATTACH A COPY OF ONE OF THE FOLLOWING PROOFS OF PAYMENT:

- ☐ Receipt, provider invoice, or statement that indicates the amount paid to the provider and the method of payment, or
- ☐ A copy of the front and back of a cleared check made out to the provider, or
- ☐ A copy of the credit card statement that includes ONLY the charges and provider's name.

24. ATTESTATION SIGNATURE IS REQUIRED. *I ATTEST THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE, AND THE SERVICES WERE RECEIVED AND PAID FOR IN THE AMOUNT REQUESTED AS INDICATED ABOVE.*

SIGNATURE

____/____/_____
TODAY'S DATE (MM/DD/YYYY)

Please submit claims within 60 days of the date of service but no later than 365 days from the date of service. Claims not received within this time frame are not eligible for benefit payment. Submission of this form does not guarantee reimbursement. For questions, please contact Customer Service at **1-800-878-4445 (TTY: 711)** or visit us online at **ProvidenceHealthPlan.com**