Member Reimbursement Form for Medical Claims

PROVIDENCE Health Plans

ONE FORM PER PATIENT PER PROVIDER

Please print clearly, complete all applicable sections and sign. Retain a copy for personal records. Proof of Payment is required. Please submit all documents to: **Providence Health Plans Attn: Claims Processing P.O. Box 3125 Portland, OR 97208-3125**

1. Patient's Name: (Last) (First) (Middle)	2. Patient's Member I.D.#:	3. Insured's Group #:
4. Patient's Address:	5. Patient's Phone Number:	6. Patient's Date of Birth:

7. **Custodial Parent Information:** For reimbursement requests from a Legal Custodial Parent not on the plan, please provide Name, contact phone # and address payment is to be mailed to:

The following information must be obtained from your provider or included on your itemized statement or bill from your provider. If the itemized statement includes the information required in fields 8-9, you do not need to complete those sections on the form. Do not send originals as they will not be returned to you.

8. Dates of Service	Place of Service (Office, ER, Urgent, Hospital, Clinic, Pharmacy, Ambulance, Home)	Diagnosis Codes (ICD-10 codes required for dates on or after 10/1/15)	Procedure Codes	Amount Charged	Amount Paid

9. Provider's Name:

Provider's Tax I.D. #:

Provider's Billing Address:

10. Other Insurance information:

Is the patient covered by another plan?

☐ Yes ☐ No

Name of other insurance company:

If the other insurance made a payment, please include Explanation of Benefits

11. Condition was related to:

A. Patient's Employment? L&I

☐ Yes ☐ No

B. Auto Accident?

☐ Yes ☐ No

C. Date of Incident:

12. Foreign Claims

For services out of the country, please explain where services were rendered (e.g. Office, Urgent Care, ER, Pharmacy) and explain nature of injury or illness:

13. Please attach one of the following proofs of payment:

☐ Copy of receipt, provider invoice or statement that indicates the amount paid to the provider and method of payment

If a receipt or invoice showing proof of payment is not available, you may provide one of the following:

☐ The front and back of the cleared check written to the provider

☐ A copy of the credit card statement that includes the charges and the provider's name.

14. 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: _____ Date: _____

We encourage claim submission within 60 days of the date of service. Claims must be received by Providence Health Plans within 365 days of 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 any questions, please contact Customer Service at 1-800-878-4445 (TTY: 711) or visit us online at www.ProvidenceHealthPlan.com.