Claim Form – Medical

Use this form to request reimbursement for a medical service that was initially paid in full and not processed through PacificSource. Reimbursements will only be made for covered services incurred by PacificSource Health Plan members covered under the plan at the time of service.

Instructions

1. Copy your original, itemized provider receipt. Retain original for your records.
2. Submit this completed form along with the copy of your receipt and proof of payment to PacificSource. (Missing or incomplete information may delay the processing of your claim.)

Email: CS@PacificSource.com
Fax: **541-225-3632**
Mail: PacificSource Health Plans, PO Box 7068, Springfield, OR 97475-0068

Member information

Member name (first, last) ______________________ Phone number ______________

Member ID number (on your ID card) ______________ Group number (on your ID card) ______________

Patient name ______________________ Patient date of birth ______________

Provider information

Provider name ______________________ Provider phone ______________

Provider address ____

Service location address ____

Provider tax ID number ______________ Provider NPI number ______________

Date of service	Description of service	Diagnosis code (ICD-10)	Procedure Code	Charge amount

Authorization/Certification

By signing below, I certify that the information provided on this claim form is correct and complete, and that I am claiming benefits only for charges actually incurred by the person listed as "patient name" above. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information, may be guilty of a criminal act punishable under law and may be subject to civil penalties. The signer agrees that any personally identifiable health information about the signer or signer's enrolled dependents is protected by the Health Insurance Portability and Accountability Act of 1996 and other privacy laws. In accordance with those laws, the Plan may use and disclose Protected Health Information for treatment, payment and health care operations as described in its Notice of Privacy Practices. The signer hereby authorizes any insurer, employer, organization, or healthcare service provider to release to the Plan all information relating to past, present, and future healthcare examinations or treatments received by each person covered by this claim/application.

Signature ______________________________________ Date ______________

Questions? Email CS@PacificSource.com or call **888-977-9299,** TTY: 711. We accept all relay calls.