Claim Form — Dental

PacificSource HEALTH PLANS

Use this form to request reimbursement for a dental 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: Dental@PacificSource.com

   Fax: 541-225-3655

   Mail: PacificSource Health Plans, PO Box 7068, Springfield, OR 97475-0068

Subscriber and member information

Subscriber name (first, last) _____

Subscriber ID number (on your ID card) _____

Group number (on your ID card) _____

Member name (who the claim is for) _____ Member date of birth _____

Provider information

Provider name _____

Provider address _____

Provider phone _____

Provider tax ID number _____ Provider NPI number _____

Date of service	Description of service (CDT or CPT & ICD10 code)	Charge amount

For questions or concerns, please call us at **866-373-7053, TTY 711** (we accept all relay calls), or email Dental@PacificSource.com.