Billings Clinic Claim Form

Please complete this form for any services you paid for out-of-pocket and are requesting reimbursement for. Submit this form with copies of your receipts to the address listed below.

Instructions:

1. Submit one form per member.
2. The receipt must be attached and itemized. It must include procedure code(s) and/or a description of service(s) rendered.
3. Charges must be indicated for each billed procedure.
4. Sign and date the form. Include a copy of your receipt. Keep a copy of the form for your records.
5. Mail or fax the completed form and receipt to:

   PacificSource Health Plans Claims Department
   PO Box 7068
   Springfield, OR 97475-0068
   Fax: (541) 225-3632

Patient Name ______________________________ Member ID Number ______________________

Member's Address ____

Date of Birth ______________________________ Health Plan ID ______________________

Date of Service ______________________________ Name of Provider ______________________

By signing, I am certifying that the above information is true and accurate.

Signature of Person Completing this Form ______________________________ Date ______________

Questions?

PacificSource Customer Service
(888) 246-1370
TTY: (800) 253-4091
cs@pacificsource.com
PacificSource.com/BillingsClinic