Legacy Employee Health Plan

Health claim reimbursement request form

PacificSource HEALTH PLANS

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

Instructions

1. Copy your original, itemized receipt. Retain original for your records.
2. Submit this completed form along with the copy of your itemized receipt to PacificSource. If sufficient documentation is not received, your claim will not be processed. This form must be submitted within 12 months of the service date to be considered for reimbursement.

Email: LegacyEHP@PacificSource.com
Fax: 541-225-3632

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

Member information

Member name _____

Member ID no. (on your ID card) _____

Group no. G0035912 _____

Patient name _____ Patient date of birth _____

Provider or phamacy information

Provider name _____

Provider address _____

Provider phone _____

Provider tax ID no. _____ Provider NPI no. _____

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

If you have any questions or concerns, call our Customer Service team at 844-520-5347 or email LegacyEHP@PacificSource.com.