# Health Claim Reimbursement Request Form

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<br>PO Box 7068, Springfield, OR 97475-0068

## Member Information

Member Name (first, last) ______________________________

Member ID Number (on your ID card) ______________________________

Group Number (on your ID card) ______________________________

Patient Name ____________________ Patient Date of Birth ____________

## Provider Information

Provider Name ______________________________

Provider Address ______________________________

Provider Phone ______________________________

Provider Tax ID No. ____________________ Provider NPI No. ____________

| Date of Service | Description of Service (CPT & ICD10 code) | Charge Amount |
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For questions or concerns, please call PacificSource at (888) 977-9299.