

Member Reimbursement Form for Medical Claims



ONE FORM PER PATIENT PER PROVIDER

Please print clearly, complete all applicable sections and sign.

1. Member's Name: (Last) (First) (Middle)			2. Member ID#:	3. Group ID#:
4. Member's Address:		5. Phone Number	6. Date of Birth:	

*The following information must be obtained from your provider or included on your itemized statement or bill from your provider. If the itemized statement includes the information required provider and services rendered information, you do not need to complete those sections on the form. Do not send originals as they will not be returned to you.*

7. Dates of Service	Place of Service (Office, ER, Urgent care, Hospital, Clinic, Pharmacy, Ambulance, Home)	Diagnosis Codes (ICD-10)	Procedure Codes	Amount Charged	Amount Paid

For Vision requests, please mark one:  Post-cataract  Routine

8. Provider's Name: _____ Provider's Tax ID#: _____ Provider's Billing Address: _____ _____ Provider's NPI (not required): _____	9. Other Insurance information: Is the member covered by another plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of other insurance company: _____ If the other insurance made a payment, please include Explanation of Benefits	10. Condition was related to: A. Patient's Employment? <input type="checkbox"/> Yes <input type="checkbox"/> No B. Auto Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No C. Date of Incident: _____
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11. For Wig requests, was the wig purchased due to hair loss that is a result of chemotherapy?  Yes  No

12. Foreign Claims  
*For services out of the country, please explain where services were rendered (Office, ER, Urgent care, Hospital, Clinic, Pharmacy) and explain nature of injury or illness:*

13. Signature (required):  
*I attest that the information above is true and accurate, and the services were received and paid for in the amount requested as indicated above.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please provide a copy of your receipt, a provider invoice or a statement that indicates the amount paid to the provider and method of payment, then mail this completed form along with your copy of payment to:

**Attn: Claims Processing, Providence Medicare Advantage Plans, P. O. Box 4327, Portland, OR 97208-4327**

Claims must be received by Providence Medicare Advantage Plans within 365 days of the date of service. Claims not received within this timeframe are ineligible for benefit payment. Submission of this form does not guarantee reimbursement. . If you have any questions, please call Providence Medicare Advantage Plans at 503-574-8000 or 1-800-603-2340. TTY users should call 711. We are open seven days a week, between 8 a.m. and 8 p.m. (Pacific Time). Between April 1st and September 30th we are closed Saturdays and Sundays.