PROVIDENCE Health Plan

# Medical Claim Form

Most providers will submit a claim for health care services to Providence Health Plan on your behalf. There are some instances, however, when the physician or other medical provider does not provide this claims service, and you are responsible for paying the full bill for health care services at the time you receive them. In cases such as these, you must request an itemized bill from the provider's office. Itemized bills must include the:

- Date of service
- Name, address, tax identification number, national provider index ("NPI") number and address of the physician or other medical provider who provided the service
- Diagnosis and procedure code(s) and
- Amount charged for each service.

Please send a copy of the itemized bill along with your proof of purchase (payment receipt) and this completed form to:

Providence Health Plans
ATTN: Claims Processing
P.O. Box 3125
Portland, OR 97208-3125

**Note:**
Your Summary of Benefits and Member Handbook describe covered services under your health plan. Covered services are subject to your eligibility at the time the service is received, and the terms and conditions of your plan. **Submission of this form does not guarantee reimbursement.**

You are encouraged to submit claim(s) within 60 days of the date of service. Claims must be received by Providence Health Plan within 365 days of the date of service; claims not received within this time frame are not eligible for benefit payment.

If you have questions, please contact Customer Service at 503-574-7500 (toll-free 1-800-878-4445; TTY 503-574-8702 / 1-888-244-6642) or via the Web at www.providence.org/healthplans.

You can learn the status of your claim at any time by logging on to myProvidence at www.providence.org/healthplans.

| PATIENT & INSURED (SUBSCRIBER) INFORMATION | | | |
|---|---|---|---|
| PATIENT'S NAME (FIRST, MIDDLE INITIAL, LAST NAME) | PATIENT'S DATE OF BIRTH | PATIENT"S SEX<br>M☐ F☐ | MEMBER I.D. NO. |
| PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE) | | | |
| INSURED'S NAME (FIRST, MIDDLE INITIAL, LAST NAME) | INSURED'S GROUP NO. | INSURED I.D. NO. | |
| INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE) | | | |
| PLEASE INCLUDE DETAILS IF THE SERVICES ARE THE RESULT OF AN EMERGENCY OR ACCIDENTAL INJURY | | | |