PROVIDENCE
Medicare Advantage Plans
A division of Providence Health Assurance

Providence Health Assurance
Special Investigations Unit (SIU)
External Referral Form

Today's Date: _____

About You:
Full Name: _____
Address: _____
_____
Phone: _____
Email: _____

Are you a Providence Health Assurance Member?
☐Yes ☐No
If yes, please provide your Member ID number: _____

About the issue being referred for review:
Is the Member involved a Medicare or Medicaid Member?
☐Yes ☐No ☐Unknown
Describe the issue using as much detail as you can. Include date(s) of service, claim number, or other identifying detail (if possible):

SEND BY MAIL OR FAX: Feel free to attach any supportive information, such as correspondence.	
Mail: Providence Health Assurance Attention: SIU PO Box 3150 Portland, OR 97208-4327	FAX: 503-574-8142 (Secure Fax)

Clear Form Print Form