

## Alternative Care Claim Form – For Providers

Many alternative care providers will submit a claim for health care services to Providence Health Plan on your behalf. If your provider’s office will not submit a claim, you can use this claim form for any alternative care reimbursement requests you may have. Your provider can help you complete this form or provide an itemized bill with the information we need to process your claim. 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) **OR** 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 Benefit Summary 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](http://www.providence.org/healthplans).

You can learn the status of your claim at any time by logging in to myProvidence at [www.providence.org/healthplans](http://www.providence.org/healthplans).

<b>PATIENT &amp; SUBSCRIBER INFORMATION</b>			
PATIENT’S NAME (FIRST, MIDDLE INITIAL, LAST NAME)	PATIENT’S BIRTH DATE	PATIENT’S SEX  M    F	MEMBER ID NO.
PATIENT’S ADDRESS (STREET, CITY, STATE, ZIP CODE)			
SUBSCRIBER’S NAME (FIRST, MIDDLE INITIAL, LAST NAME)	GROUP NO.	SUBSCRIBER’S ID NO.	
SUBSCRIBER’S ADDRESS (STREET, CITY, STATE, ZIP CODE)			

**OVER →**

**(CONTINUED FROM REVERSE SIDE)**

**DETAILS OF SERVICE**

PLEASE INCLUDE DETAILS IF THE SERVICES ARE THE RESULT OF AN EMERGENCY OR ACCIDENTAL INJURY

NOTE: LIST EACH DATE OF SERVICE INDIVIDUALLY – DO NOT USE A DATE SPAN.

Date(s) of Service	Procedure Code (CPT / HCPCS)	Modifier(s)		Units	Charges

RENDERING PROVIDER NAME, ADDRESS, ZIP CODE AND PHONE:

NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED:

TAX ID, AND NPI OR PIN NUMBERS:

## Non-discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance  
Attn: Non-discrimination Coordinator  
PO Box 4158  
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue SW - Room 509F HHH Building  
Washington, DC 20201  
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-878-4445 (TTY: 711)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-878-4445 (TTY: 711).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់ប្រើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-878-4445 (TTY: 711)។

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

دیوری بگ. شما یرا گان یرا بصورت یر زبان لات یر تسه، دی کن یم گفتگ و یر فارس زبان به اگر: توجه  
ف یم باشد. یا (TTY: 711) 1-800-878-4445 تماس

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS : 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)