Member Reimbursement Form for Medical Claims

ONE FORM PER PATIENT PER PROVIDER
Please print clearly, complete all applicable sections and sign. Retain a copy for personal records. Proof of Payment is required. Please submit all documents to: **Providence Health Plans Attn: Claims Processing P.O. Box 3125 Portland, OR 97208-3125**

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

7. **Custodial Parent Information:** For reimbursement requests from a Legal Custodial Parent not on the plan, please provide Name, contact phone # and address payment is to be mailed to:

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 in fields 8-9, you do not need to complete those sections on the form.
Do not send originals as they will not be returned to you. For durable medical equipment or supplies, doctor's order/prescription required.

8. Dates of Service	Place of Service (Office, ER, Urgent, Hospital, Clinic, Pharmacy, Ambulance, Home)	Diagnosis Codes (ICD-10 codes required for dates on or after 10/1/15)	Procedure Codes	Amount Charged	Amount Paid

9. Provider's Name:

Provider's Tax I.D. #:

Provider's Billing Address:

10. Other Insurance information:

Is the patient covered by another plan?

☐ Yes ☐ No

Name of other insurance company:

If the other insurance made a payment, please include Explanation of Benefits

11. Condition was related to:

A. Patient's Employment? L&I
☐ Yes ☐ No

B. Auto Accident?
☐ Yes ☐ No

C. Date of Incident:

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

13. Please attach one of the following proofs of payment:

☐ Copy of receipt, provider invoice or statement that indicates the amount paid to the provider and method of payment

If a receipt or invoice showing proof of payment is not available, you may provide one of the following:

☐ The front and back of the cleared check written to the provider

☐ A copy of the credit card statement that includes the charges and the provider's name.

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

Signature: ______________________ Date: ______________________

We encourage claim submission within 60 days of the date of service. Claims must be received by Providence Health Plans within 365 days of the date of service; claims not received within this time frame are not eligible for benefit payment. Submission of this form does not guarantee reimbursement. For any questions, please contact Customer Service at 1-800-878-4445 (TTY: 711) or visit us online at www.ProvidenceHealthPlan.com.

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ゐ!

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៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ 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).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 711) 1-800-878-4445 تماس بگیرید.

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)