PacificSource HEALTH PLANS

Health Claim Reimbursement Request Form

Use this form to request reimbursement for a medical service that was initially paid in full and not processed through PacificSource. Reimbursements will only be made for covered services incurred by PacificSource Health Plan members covered under the plan at the time of service.

Instructions

1. Copy your original, itemized provider receipt. Retain original for your records.
2. Submit this completed form along with the copy of your receipt and proof of payment to PacificSource. (Missing or incomplete information may delay the processing of your claim.)

   Email: cs@pacificsource.com

   Fax: (541) 225-3632

   Mail: PacificSource Health Plans
   PO Box 7068, Springfield, OR 97475-0068

Member Information

Member Name (first, last) _____

Member ID Number (on your ID card) _____

Group Number (on your ID card) _____

Patient Name _____ Patient Date of Birth _____

Provider Information

Provider Name _____

Provider Address _____

Provider Phone _____

Provider Tax ID No. _____ Provider NPI No. _____

Date of Service	Description of Service (CPT & ICD10 code)	Charge Amount

For questions or concerns, please call PacificSource at (888) 977-9299.