Claim Form — Medical

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 number ______________________ Provider NPI number ______________________

Date of service	Description of service (CPT & ICD10 code)	Charge amount

If COVID-19 test

Test is related to: Employment Travel Symptomatic or Exposure to COVID-19-positive individual

Other: ______________________________

If the COVID-19 test is for employment or travel purposes, it may not be covered.

Request for reimbursement of At-Home COVID-19 tests must be submitted to Caremark.com. Sign in or register, then follow the prompts to upload a copy of your receipt. (Instructions.) Or submit a paper claim to Caremark.

For questions or concerns, please call us at **888-977-9299, TTY 711** (we accept all relay calls), or email CS@PacificSource.com.