MEMBER REIMBURSEMENT CLAIM

Samaritan Health Plan Operations

SELECT YOUR PLAN:		
❑ Samaritan Advantage	❑ Samaritan Choice	❑ Samaritan Employer Group Plans

MEMBER INFORMATION:		
Member name:	Date submitted:	Member ID #:
Address:		Phone:
Patient name (if different than member):		Date of birth:

PROVIDER / SERVICE INFORMATION:		
Servicing provider:	Phone:	
Clinic or facility:	Address:	
Diagnosis code(s):		Date(s) of service:
Procedure code(s):	Items purchased:	
Description of charges: (office visit, prescriptions, etc.)		Amount paid: $

Payment type: ❑ Cash/check ❑ Credit/debit ❑ Flexible Spending Account (FSA) ❑ Other_____

MEMBER OR AUTHORIZED REPRESENTATIVE STATEMENT

I attest that the above information is true and accurate and that the services were received and paid for in the amount requested as indicated above. I acknowledge that if any information on this form is misleading or fraudulent my coverage may be cancelled and I may be subject to criminal and/or civil penalties for false health care claims. I understand that reimbursement payment will be made to the Plan subscriber and will contain information about the service (e.g., provider name, date, description of service). I also understand that Samaritan Health Plans may request any additional information it deems necessary to verify that services were received and payment was made.

Signature: _____ **Date:** _____

DOCUMENTATION REQUIRED: Samaritan Health Plans requires proof that the services were rendered and that the member has paid for these services. In order for Samaritan Health Plans to process your request, you *must* provide copies of the following:

1. **Provider statement or bill,** showing name of provider, date of service, diagnosis code (s), procedure code (s) performed and charges.
2. **Customer receipt or statement** (showing payments applied to your account) or **cancelled check** showing that member has paid for services rendered.
3. If you have other insurance coverage and they are your primary insurance, a copy of their **statement or EOB (explanation of benefits)** is also required.
4. This form must be accompanied with **all receipts and supporting documentation** to be considered for reimbursement

Claims received by Samaritan Health Plans with incomplete documentation will be returned to the member for completion. Complete claims will be processed within 30 days of receipt.

You may mail your claim to us at the address below or fax your claim to us at (541) 768-5309.

Samaritan Health Plan Operations
PO Box 1310
Corvallis, OR 97339

FOR OFFICE USE ONLY:	Date received:	By: