Sutter Health Partners
With You. For Life.

MAIL TO:
BRMS
North Bay Health Partners
PO Box 2650
Rancho Cordova, CA 95741

MEMBER SUBMITTED MEDICAL CLAIM FORM

GENERAL INSTRUCTIONS: Type or print. Complete a separate claim for each patient. Attach itemized receipts. Do not staple items. Be sure to sign the form. Do not submit a claim if the doctor or hospital is also filling a claim for the same service. PRESCRIPTION DRUGS MUST BE completed on the PRESCRIPTION DRUG CLAIM FORM. Thank you.

SECTION I: PATIENT INFORMATION

1. YOUR MEMBER ID MUST BE COMPLETE IN ORDER TO PROCESS YOUR CLAIM.

2. PATIENT'S NAME (LAST NAME) (FIRST NAME) (MIDDLE INITIAL)	3. PATIENT'S DATE OF BIRTH MONTH DAY YEAR	4. PATIENT'S SEX MALE ☐ FEMALE ☐	5. PATIENT'S RELATIONSHIP TO MEMBER SELF ☐ SPOUSE ☐ CHILD ☐

6. DOES THE PATIENT HAVE OTHER HEALTH INSURANCE COVERAGE? ☐YES ☐ NO(IF NO, MOVE TO BOX NO. 7)

A. NAME OF OTHER POLICY HOLDER_____
B. NAME OF OTHER EMPLOYER _____
C. POLICY OR OTHER CERTIFICATE NUMBER_____
D. NAME OF OTHER INSURANCE COMPANY _____

7. WAS CONDITION RELATED TO:

A. PATIENT'S EMPLOYMENT ☐YES ☐ NO
B. AUTO ACCIDENT ☐YES ☐ NO
C. OTHER ACCIDENT ☐YES ☐ NO
D. DATE OF ONSET_____

SECTION II: MEMBER INFORMATION AND STATEMENT

8. MEMBER'S NAME(LAST, FIRST, MIDDLE INITIAL)

STREET ADDRESS OR ROUTE AND BOX NUMBER

CITY STATE ZIP CODE

TELEPHONE: (DAYTIME) (EVENING)

9. PLEASE GIVE A DIAGNOSIS FOR EACH SERVICE SUBMITTED

I CERTIFY THAT THE INFORMATION ON THIS FORM IS CORRECT AND THE EXPENSES INCURRED WERE NECESSARY FOR THE TREATMENT OF THE CONDITIONS INDICATED.

MEMBER'S SIGNATURE_____ DATE CLAIM SUBMITTED_____

SECTION III: SERVICES NOT FILED BY DOCTOR OR HOSPITAL

(Office visits, hospital visits, physical therapy, ambulance, durable medical equipment, medical supplies, etc.)

DATE OF SERVICE MO/DAY/YR	TYPE OF SERVICE (DESCRIBE BRIEFLY) WE CANNOT ACCEPT CANCELED CHECKS, "PAID ON ACCOUNT" ENTRIES, "BALANCE DUE" ENTRIES, OR CASH REGISTER RECEIPTS AS PROOF OF SERVICES.	CHARGE	
05/10/90	EXAMPLE Office Visit	$ 25.	00
05/10/90	EXAMPLE Chest X-ray	$ 30.	00

EACH SERVICE CHARGE MUST BE LISTED SEPARATELY. PLEASE ATTACH ALL ITEMIZED RECEIPTS.

If the patient is covered under any other health insurance, a copy of the Explanation of Benefits from the other health insurance carrier showing how much was paid for these services must be attached.

Please submit claim forms within 120 days of date of service.
If you have questions, please call us at 1-888-326-2555.