

# medical claim form

## PHS - Alaska



PATIENT & INSURED (SUBSCRIBER) INFORMATION			
PATIENT NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)	PATIENT'S DATE OF BIRTH	PATIENT'S SEX <input type="checkbox"/> M <input type="checkbox"/> F	PARTICIPANT ID NO.
PATIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)			
INSURED'S NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)		INSURED'S GROUP NO. (OR GROUP NAME)	
INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)			
IS PATIENT COVERED BY ANY OTHER INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO <span style="float: right;">IF YES, PLEASE COMPLETE THE FOLLOWING:</span>			
INSURANCE COMPANY		GROUP NO.	
INSURED'S NAME		ID NO.	
ADDRESS TO SUBMIT CLAIMS			

IF MEDICAL TREATMENT IS THE RESULT OF AN INJURY OR ACCIDENT, PLEASE COMPLETE THE FOLLOWING SECTION.		
NATURE OF INJURY <input type="checkbox"/> AUTO <input type="checkbox"/> MOTORCYCLE <input type="checkbox"/> WORK <input type="checkbox"/> HOME <input type="checkbox"/> OTHER _____	DATE OF INJURY	LOCATION
OTHER PARTIES INVOLVED? <input type="checkbox"/> YES <input type="checkbox"/> NO	WERE OTHER MEMBERS OF FAMILY INJURED IN ACCIDENT? (IF SO, PLEASE LIST NAMES)	
IF AUTO ACCIDENT, PLEASE LIST NAME & ADDRESS OF YOUR AUTO INSURANCE COMPANY		
AUTO POLICY NO.	CLAIM NO.	OTHER PARTY'S INSURANCE CO. POLICY NO. CLAIM NO.
DO YOU PLAN TO OBTAIN AN ATTORNEY? IF YES, PLEASE LIST NAME & ADDRESS & PHONE NO.		
DO YOU PLAN TO TAKE ACTION TO RECOVER COMPENSATION FOR YOUR INJURIES? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT KIND OF ACTION? <input type="checkbox"/> CONTACT WITH OTHER PARTY'S INSURANCE COMPANY	
ANY OTHER ACTION TAKEN?		
I HEREBY CERTIFY THAT ALL INFORMATION GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE <b>X</b>		DATE

PHYSICIAN OR SUPPLIER INFORMATION							
NAME OF REFERRING PHYSICIAN OR OTHER SOURCE				FOR SERVICES RELATED TO HOSPITALIZATION, LIST DATES ADMITTED DISCHARGED			
NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)							
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATED DIAG. TO PROCEDURE IN DIAGNOSIS CODE COLUMN REF. NO. 1,2,3, ETC. OR DIAG. CODE							
1) 2) 3)							
DATE OF SERVICE	PLACE OF SERVICE	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE	DIAGNOSIS CODE	CHARGES	DAYS OR UNITS	LEAVE BLANK	
SIGNATURE OF PHYSICIAN OR SUPPLIER			PHYSICIAN OR SUPPLIER SOCIAL SECURITY NO.	TOTAL CHARGE	AMOUNT PAID	BALANCE DUE	
YOUR PATIENT'S ACCOUNT NO. YOUR EMPLOYER ID NO.			PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & PHONE NO.				
SIGNATURE OF PHYSICIAN			ID NO.				

Please remember to attach receipts suitable for insurance billing purposes.  
Mail your claim to: **Providence Health Plan, P.O. BOX 4447 PORTLAND, OR 97208-4447**