MEMBER REIMBURSEMENT CLAIM

Samaritan Health Plans

SELECT YOUR PLAN:		
☐ Samaritan Advantage (SAHP) ☐ Samaritan Choice (SCP) ☐ Samaritan Employer Group Plans (COMM)		
MEMBER INFORMATION:		
Member name:	Date:	Member ID #:
Address*:		Phone:
* The reimbursement will be mailed to the address Samaritan Health Plans has on file. If you have a new address, for SAHP please contact us, for SCP and COMM please contact your employer to get it updated in our system.		
Patient name (if different than member):		Date of birth:
PROVIDER / SERVICE INFORMATION:		
Servicing provider:	Phone:	NPI:
Clinic or facility:	Address:	Tax ID:
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 canceled 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. It will be sent to the address Samaritan Health Plans has on file 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. 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. For SAHP – we cannot pay for services provided by a provider who has opted out of Medicare.
2. **Customer receipt or statement** (showing payments applied to your account) or **canceled check** showing that the 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 Plans
PO Box 1310
Corvallis, OR 97339

FOR OFFICE USE ONLY	Date received:	By: