

MEMBER REIMBURSEMENT CLAIM

SELECT YOUR PLAN:			
<input type="checkbox"/> Samaritan Advantage	<input type="checkbox"/> Samaritan Choice	<input type="checkbox"/> COHO	<input type="checkbox"/> Samaritan Healthy Kids
MEMBER INFORMATION:			
Member Name:		Date Submitted:	Member ID #:
Address:			Telephone #:
Patient Name (if different than Member):			DOB:
PROVIDER / SERVICE INFORMATION:			
Servicing Provider:		Telephone #:	
Clinic or Facility:		Address:	
Diagnosis Code (s):			Date(s) of Service:
Service(s), Procedure Code (s), or Item(s) Purchased:			
Charges:		Amount Paid:	

DOCUMENTATION REQUIRED: Samaritan Health Plans requires proof that the services were rendered and that the member has paid for these services. 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.

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: