PRESBYTERIAN

Presbyterian Health Plan, Inc.
Presbyterian Insurance Company, Inc.

Member Medical Claim Form

If you would like help submitting this claim form, please contact the Presbyterian Customer Service Center by emailing **info@phs.org**, calling the number on the back of your member ID card, or using the following phone numbers:

Commercial Plans			
Presbyterian Health Plan			
Phone:	(505) 923-5678 1-800-356-2219 TTY: 711	**Hours:**	Monday - Friday 7 a.m. to 6 p.m. (except holidays)
Presbyterian Insurance Company			
Phone:	(505) 923-6980 1-800-923-6980 TTY: 711	**Hours:**	Monday - Friday 7 a.m. to 6 p.m. (except holidays)
Medicare Advantage Plans			
Presbyterian Senior Care (HMO) / (HMO-POS) | Presbyterian UltraFlex (HMO-POS)			
Phone:	(505) 923-6060 1-800-797-5343 TTY: 711	**Hours:**	**October 1 - March 31** 8 a.m. to 8 p.m., seven days a week (except holidays) **April 1 - September 30** 8 a.m. to 8 p.m., Monday - Friday (except holidays)
Presbyterian Dual Plus (HMO D-SNP)			
Phone:	(505) 923-7675 1-855-465-7737 TTY: 711	**Hours:**	**October 1 - March 31** 8 a.m. to 8 p.m., seven days a week (except holidays) **April 1 - September 30** 8 a.m. to 8 p.m., Monday - Friday (except holidays)

Please submit claim forms to:		
Presbyterian Health Plan, Inc. P.O. Box 27489 Albuquerque, NM 87125-7489	OR	Presbyterian Insurance Company, Inc. P.O. Box 26267 Albuquerque, NM 87125-6267

Si desea recibir información en español sobre el contenido de este documento, favor de llamar al Centro de Servicio al Cliente de Presbyterian al número que se encuentra al dorso de su tarjeta de asegurado.

MEDICAL CLAIM FILING INSTRUCTIONS

Please read these instructions completely. Please look at your Presbyterian Health Plan member ID card and your provider's invoice when completing this form.

1. Member Medical Claim Forms are only required if the provider will not file a claim on your behalf.
2. This claim form must be completed with **black or blue ink only**. Please print legibly.
3. Questions must be answered with complete details given for any checked or "yes" answers. You are responsible for the accuracy and completeness of all information entered on this form. Incomplete claim forms may result in delays. If more space is needed, attach a separate page(s) and list sections and question numbers. Then, sign and date each page.
4. Attach a copy of the itemized statement or charge form and **include all of the items on the following checklist:**

- ☐ Patient's name
- ☐ Date of each service
- ☐ Detailed description of service or procedure code
- ☐ Amount of each charge for each procedure
- ☐ Diagnosis code
- ☐ Proof of payment
- ☐ Provider's name and address
- ☐ Provider's Federal Tax ID Number
- ☐ National Provider Identifier (NPI) Number

SECTION 1: MEMBER INFORMATION

The member or primary policy holder must complete this section.

First Name, MI, Last Name	Gender ☐ M ☐ F	DOB (m/d/yyyy)	Member ID #:		
			Group # (if applicable):		
Address (No P.O. Boxes)		City	State	County	ZIP
Home Phone	Work Phone		Email Address		

SECTION 2: PATIENT INFORMATION

Please complete for member, legal spouse or dependent child(ren) who are the patient for this claim. Dependent child(ren) must meet the terms of eligibility under your plan.

Name (First, MI, Last)	**Relation**	**Gender**	**DOB** (m/d/yyyy)
	☐ Member ☐ Spouse ☐ Dependent Child	☐ M ☐ F	
	☐ Member ☐ Spouse ☐ Dependent Child	☐ M ☐ F	
	☐ Member ☐ Spouse ☐ Dependent Child	☐ M ☐ F	

SECTION 3: CLAIM INFORMATION

1. Was the condition/treatment related to one of the following (please check one):
   - ☐ Illness diagnosed prior to enrolling with Presbyterian Health Plan
   - ☐ Auto accident
   - ☐ Patient's employment
   - ☐ Other accident
   - ☐ Other (please describe): _____

   Please provide details, including date and nature of the condition/treatment checked above. Attach extra sheets if you need more space:_____
   _____
2. Date first consulted for this condition:
3. Has the patient ever had the same symptoms? ☐ Yes ☐ No
4. Does the patient have other health insurance coverage? ☐ Yes ☐ No
   If "yes," please provide the following information:
   Policy Holder: _____Policy Number:_____
   Insurance Company:_____

SECTION 4: TREATING PROVIDER INFORMATION

Provider's Name	NPI #	Tax ID #		
Mailing Address	City	State	County	ZIP
Phone Number (include area code)	Email Address			

SECTION 5: PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

Please pay the claim to: ☐ Member ☐ Provider

I authorize the release of any medical information necessary to process this claim. All legal-aged members or the parent/legal guardian of a minor child member must personally sign and date this claim form.

Any person who knowingly presents a false or fraudulent claim for payment or a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

	X	
Member Name (please print) (Legal guardian if member is a minor)	**Member Signature** (required) (Legal guardian if member is a minor)	**Today's Date**
Member's Spouse (please print) (If one submitting claim)	**Spouse's Signature** (required) (If one submitting claim)	**Today's Date**

Based on a Model of Care review, Presbyterian Dual Plus (HMO D-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate a Special Needs Plan (SNP) through 2025. For information on Presbyterian Health Plan's Nondiscrimination Notice, go to **https://www.phs.org/nondiscrimination**.