

Member Medical and Pharmacy Claim Form

If you would like help with submitting this Claim Form, please contact the Presbyterian Customer Service Center by e-mail at info@phs.org. You may also call the number on the back of your member ID card or one of the following numbers:

Phone: (505) 923-5678 Toll-free: 1-800-356-2219

TTY Users: 711

You can reach Customer Service Monday through Friday from 7:00 a.m. to 6:00 p.m.

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

Si usted desea recibir información en español sobre el contenido de este documento, sírvase llamar a nuestro Centro de Atención a los Clientes al (505) 923-5678 o al 1-800-356-2219, de lunes a viernes, de las 7 de la mañana a las 6 de la tarde o a la línea telefónica. TTY para personas con problemas auditivos al 1-877-298-7407.

MEDICAL CLAIM FILING INSTRUCTIONS Please read these instructions completely. Please look at your Member ID card and your Provider or Practitioner's invoice when completing this form. 1. Member Medical or Pharmacy Claim Forms are only required if the Provider, Practitioner or Pharmacy 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 section(s) 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 **Diagnosis** code Date of each service **Proof of payment** Detailed description of service or procedure code Provider/Practitioner's name and address Amount of each charge for each procedure Provider/Practitioner's Federal Tax ID and/or National Provider Identifier (NPI) number PHARMACY CLAIM FILING INSTRUCTIONS 1. If the medication cost is less than the pharmacy copayment, the member is responsible for the charge; therefore, it is not necessary to file a Pharmacy Claim. 2. Prescription/Pharmacy claims must include a receipt. Cash register receipts are not acceptable. 3. Pharmacy receipts must include all of the items on the following checklist: Patient's name Quantity and amount taken daily **Prescription number** Name of Prescriber Drugname Amount of each prescription, including tax Purchase date Pharmacy's name and address

SECTION 1: MEMBER INFORM	MATION					
The Member or Primary Policy Holde	er must comple	te this section.				
FirstName, MI, LastName	Gender	DOB(m/day/yr)	Member ID Number:			
	M 🗌 F 🗌		Group Number (if applicable):			
Address (No P.O. Boxes)	·	City	Sta	ite (County	ZIPCode
HomePhone	Work/Messa	Work/MessagePhone E-mailAd		nail Address	dress	
SECTION 2: PATIENT INFORM	ATION		I			
Please complete for member, legal s child(ren) must meet the terms of eli			who are	the Patier	nt for this clair	n. Dependent
Name(FirstName, MI, LastName)		Relation			Gender	DOB(m/d/yr)
	🗌 Membe	er 🗌 Spouse	_ Deper	ndent Child	M 🗌 F 🗌	
	Membe	er 🗌 Spouse	_ Deper	ndent Child	M F	
	Membe	er 🗌 Spouse	Deper	ndent Child		
SECTION 3: CLAIM INFORMA	TION					
1. Was the condition/treatment related to		ing (please check	one):			
Illness diagnosed prior to	Auto accid	ent?	Other a	ccident?		
enrolling with Presbyterian.	Patient's e	mployment?	Other, p	lease des	cribe:	
Please provide details, including date a more space):			t checke	d above (at	ttach extra shee	ets if you need o
2. Date first consulted for this condition:	/ /					
_		es No				
3. Has the Patient ever had the same syn	nptoms? Ye					_
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