PRESBYTERIAN

Presbyterian Health Plan,
Presbyterian Insurance Company, Inc.

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: 1-877-298-7407**

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. P.O. Box 27489 Albuquerque, NM 87125-7489	OR	Presbyterian Insurance Company, Inc. P.O. Box 26267 Albuquerque, NM 87125-6267

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
- ☐ Date of each service
- ☐ Detailed description of service or procedure code
- ☐ Amount of each charge for each procedure
- ☐ Diagnosis code
- ☐ Proof of payment
- ☐ Provider/Practitioner's name and address
- ☐ Provider/Practitioner's Federal Tax ID number or IPN 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
- ☐ Prescription number
- ☐ Drug name
- ☐ Purchase date
- ☐ Quantity and amount taken daily
- ☐ Name of Prescriber
- ☐ Amount of each prescription, including tax
- ☐ Pharmacy's name and address

SECTION 1: MEMBER INFORMATION

The Member or Primary Policy Holder must complete this section.

First Name, MI, Last Name	Gender M ☐ F☐	DOB (m/day/yr)	Member ID Number:
			Group Number (if applicable):

Address (No P.O. Boxes)	City	State	County	ZIP Code

Home Phone	Work / Message Phone	E-mail 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 Name, MI, Last Name)	**Relation**	**Gender**	**DOB** (m/d/yr)
	☐ 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. ☐ Auto accident? ☐ Other accident? ☐ Patient's employment? ☐ 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 Patient have other health insurance coverage? Yes ☐ No☐

   If "yes," Policy Holder _____ Policy Number _____

   Insurance Company _____

SECTION 4: TREATING PROVIDER OR PRACTITIONER INFORMATION

Provider/Practitioner's Name:		Tax ID Number:		
Mailing Address	City	State	County	ZIP Code
Phone Number (include Area Code):		E-mail address:		

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

Please pay the claim to: ☐ Member ☐ Practitioner

I authorize the release of any medical information necessary to process this claim. All legal-age 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 OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Name of Member ***(please print)*** (or Legal Guardian if Member is a minor)	*x* **Signature of Member** ***(required)*** (or Legal Guardian if Member is a Minor)	**Today's Date**
Name of Member's Spouse If one submitting claim *(please print)*	*x* **Signature of Member's Spouse** If one submitting claim *(required)*	**Today's Date**