Providence Health Plan International Claim Form

Some providers will submit a claim for health care services to Providence Health Plan on your behalf. In these situations, you may give this form to your provider with instructions that it be sent, along with an itemized bill, to Providence Health Plan at the following address:

Providence Health Plans
ATTN: Claims Processing
P.O. Box 3125
Portland, OR 97208-3128

However, when the provider does not offer claims service, you are responsible for making payment arrangements. In these situations please fill out your personal information in the spaces provided below, making sure to check the appropriate box indicating where payment should be sent. Ask your provider to complete the section regarding the services you received.

When completed please submit this form, together with an itemized bill from your provider and payment receipt, to the Providence Health Plan address above or by email to phpcustomerservice@providence.org

Itemized bills should include:

- Date of service;
- Name, address and tax identification number (if available) of your provider;
- Diagnosis and procedure code(s); and
- Amount charged for each service.

You or your provider are encouraged to submit claim(s) within 60 days of the date of service. Claims must be received by PHP within 365 days of the date of service; claims not received within this time frame are not eligible for payment.

If you or your provider have questions, please contact Customer Service at 888-549-4902 or 503-574-5500 (TTY 503-574-8702 /888-244-6642) or via the Web at **www.providence.org/healthplans**. You can learn the status of your claim at any time by logging on to myProvidence at **www.providence.org/healthplans**.

PATIENT & INSURED (SUBSCRIBER) INFORMATION			
PATIENT'S NAME (FIRST, MIDDLE INITIAL, LAST NAME)	PATIENT'S DATE OF BIRTH	PATIENT'S SEX M___ F___	MEMBER I.D. NO.
PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)			
SUBSCRIBER'S NAME (FIRST, MIDDLE INITIAL, LAST NAME)			
SUBSCRIBER'S ADDRESS (STREET, CITY, STATE, ZIP CODE)			
HEALTH CARE PROVIDER: PLEASE DESCRIBE PATIENT'S ILLNESS, INJURY, OR CONDITION REQUIRING TREATMENT			
PLEASE CHECK THE APPROPRIATE BOX ☐ Make payment to subscriber; provider has been paid (see attached receipt) ☐ Make payment to provider/hospital/doctor			

Note: Your Summary of Benefits and Member Handbook describe covered services under your health plan. Covered services are subject to your eligibility at the time the service is received, and the terms and conditions of your plan. **Submission of this form does not guarantee reimbursement.**