MEDICAL CLAIM FORM for REIMBURSEMENT

(Not to be used for pharmacy reimbursement)

PARTNERSHIP HEALTHPLAN of CALIFORNIA

If you have received a bill that you have not paid, do not complete this form. Call us as soon as possible at (800) 863-4155 for assistance. TTY users can call the California Relay Service at (800) 735-2929 or call 711.

Section 1. Member Information (person who received the services)

First name	Last name		M.I.
Street address (please include apt. no.)	City	State	Zip code
Phone no.	Best time of day to reach you		
PHC ID Card no.	Date of birth (MM/DD/YYYY)		

Section 2. If we have questions about this form, who do you give us authorization to speak to? Your authorization is good until this claim has been resolved or up to 12 months.

First name	Last name
Phone no.	Best time of day to reach you
Relation to Member: ☐ Self ☐ Spouse ☐ Son ☐ Daughter ☐ Other	

Section 3. If approved, who should the check be made out to? Where do you want it mailed?

(Payment is not guaranteed)

First name	Last name		
Street address (please include apt. no.):	City	State	Zip code

Section 4. Tell us the reason why these services were paid for?

I certify that, to the best of my knowledge, the information on this **Medical Claim Form** is true and correct.

Signature	Printed name	Date (MM/DD/YYYY)

Completion of this form does not guarantee reimbursement or payment.

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How to use this form

This form is **only** to be used if you have paid for Medi-Cal covered services. This form is not to be used for pharmacy reimbursement.

Use a separate claim form for each member who received services.

Include all required documentation:

1. Itemize bill (bill that lists all the services received)
2. Proof of payment
3. Medical notes for out of state services (notes taken by doctor at time of visit)

You must complete all sections of this form and **include all the required documents listed above**. If we need more information, we will contact you.

Section 1. Member Information

This section is for the member who got the services.

Section 2. Who do we contact if we have questions?

This section is asking for information for the person we can call if we have any questions about this form or services.

Section 3. If approved, who do you want the check payable to?

This section is asking for information on who the check should be made out to and where to mail.

Section 4. Tell us the reason why these services were paid for?

This sections is to let us know why these services were paid for.

Fax or mail this completed form and required documents to PHC.

Lake, Marin, Mendocino, Napa, Solano, Sonoma, or Yolo county members:

- Fax to: (707) 863-4415
- Mail to: 4665 Business Center Drive, Fairfield CA 94534

Del Norte, Humboldt, Lassen, Modoc, Shasta, Siskiyou, and Trinity county members:

- Fax to: (530) 223-2508
- Mail to: 3688 Avtech Parkway, Redding CA 96002

We will send you a letter telling you of our decision within thirty (30) days of your request.

If you have questions or need any assistance, please call us at (800) 863-4155. We are here to help you Monday – Friday from 8 a.m. – 5 p.m. TTY users can call the California Relay Service at (800) 735-2929 or call 711.