Claim Form — Dental

Use this form to request reimbursement for a dental service that was paid directly to a provider. Reimbursements will be made for covered services incurred by PacificSource Medicare members covered under the plan at the time of service.

Instructions

1. Copy your original, itemized provider receipt. Retain the original for your records.
2. Submit this completed form along with the copy of your itemized receipt to PacificSource. (Missing or incomplete information may delay the processing of your claim.)

   Email: MedicareCS@PacificSource.com

   Fax: 541-322-6423

   Mail: PacificSource Medicare Customer Service, PO Box 7469, Bend, OR 97708

Subscriber and member information

Subscriber name (first, last) _____

Subscriber ID number (on your ID card) _____

Group number (on your ID card) _____

Member name (who the claim is for) _____ Member date of birth _____

Provider information

Provider name _____

Provider address _____

Provider phone _____

Provider tax ID number _____ Provider NPI number _____

Date of service	Description of service (CDT or CPT, tooth #, and surface/s)	Charge amount

For questions or concerns, please call us at **888-863-3637,** TTY: 711 (we accept all relay calls), or email MedicareCS@PacificSource.com.

PacificSource Community Health Plans is an HMO, HMO D-SNP, and PPO plan with a Medicare contract and a contract with Oregon Health Plan (Medicaid). Enrollment in PacificSource Medicare depends on contract renewal.