PacifiCare®
POS Medical Claim Form

INSTRUCTIONS FOR SUBMITTING CLAIMS

1. Use a separate form for each family member, each different provider of service, and each itemized bill.
2. Attach a fully itemized bill or ask the provider to complete the other side of this form.
   FULLY ITEMIZED BILLS MUST CONTAIN THE FOLLOWING INFORMATION:
   Date of service, diagnosis, type of service, procedure number, charge for each service, provider name, address, phone #, provider tax ID number.
3. A signature line for AUTHORIZATION TO PAY PROVIDER is given below. This directs PacifiCare to pay the provider. If you choose not to sign this authorization, benefits will be paid to you.
4. Please send claims to PacifiCare: P.O. Box 6019 • Cypress, CA 90630-6019
5. If you have any questions regarding your claim or need additional claim forms, please call: 1-800-913-9133.
6. Reimbursement of pharmacy expense is outlined in your membership materials. (Do not use this form for pharmacy claims.)

EMPLOYEE INFORMATION (Complete For All Claims)

Employer Name		Group Number		
Employee's Name *(Last, First M.I.)*		Employee's Street Address		
Employee's Date of Birth	Employee's SSN	City	State	Zip Code
This claim is for: ❑ Self ❑ Spouse ❑ Child ❑ Other - Please specify				

PATIENT INFORMATION

Patient's Name *(Last, First M.I.)*		Patient's Date of Birth	PacifiCare ID#
Patient is *(Check if applicable)* ❑ Female ❑ Male ❑ Married ❑ Single ❑ Disabled ❑ On Medicare ❑ Retired ❑ Student		If patient is disabled, give date of disability	
Patient was treated for: ❑ Illness ❑ Pregnancy ❑ Injury at Work ❑ Accidental Injury ❑ Other - Please specify			
If accident involved, give date, how and where accident occurred			
Does patient have other health coverage? ❑ Yes ❑ No	If Yes, Name of Insurance Company	Group Number	Policy Number
Address of Insurance Company			
Name of Policy Holder		Sex of Policy Holder ❑ Male ❑ Female	Policy Holder's Date of Birth
Name of Policy Holder's Employer		Policy Holder's Employer's Address	

AUTHORIZATIONS

RELEASE OF INFORMATION
I hereby authorize the release of any medical information necessary to process this claim.

Patient's or Authorized Person's Signature **Date**

AUTHORIZATION TO PAY BENEFITS TO PROVIDER
I hereby authorize benefits to be paid directly to the provider of service for this claim.

Patient's or Authorized Person's Signature **Date**

PLEASE ATTACH AN ITEMIZED BILL OR ASK THE PROVIDER OF SERVICE TO FILL OUT THE OTHER SIDE OF THIS CLAIM FORM

PC3313
CM-699-10000.5

PHYSICIAN OR SUPPLIER INFORMATION

Date of illness (first symptom) OR injury (accident) OR pregnancy (LMP)	Date you were first consulted for this condition	If patient has had same or similar injury, give dates	If emergency, check here ❑

Date patient able to return to work	Dates of total disability FROM	Dates of total disability THROUGH	Dates of partial disability FROM	Dates of partial disability THROUGH

Name of referring physician or other source (e.g., Public Health Agency)	For services related to hospitalization, give dates ADMITTED	DISCHARGED

Name and address of facility where services were rendered (if other than home or office)	Was laboratory work performed outside your office? ❑ YES ❑ NO

Diagnosis or nature of illness or injury
1
2
3
4
Please relate diagnosis to procedures using reference numbers (1,2,3, etc.)

FAMILY PLANNING ❑ YES ❑ NO

Prior Authorization # (if applicable)

Date of Service	Place of Service	Procedure Code	Fully describe procedures, medical services, or supplies for each date (explain unusual services or circumstances)	Diagnosis Code	Charges	Days or units	TDS	For PacifiCare use only

Patient's Account #	Total Charge	Amt Paid	Balance Due

Provider's Name	Provider's Address
Provider's Phone #	**Provider's Tax ID #**

21	(IH)	INPATIENT HOSPITAL	12	(H)	PATIENT'S HOME	32	(NH)	NURSING HOME	99	(OL)	OTHER LOCATIONS
22	(OH)	OUTPATIENT HOSPITAL	52	(PSY)	DAY CARE FACILITY	31	(SNF)	SKILLED NURSING FACILITY	81	(IL)	INDEPENDENT LABORATORY
11	(O)	DOCTOR'S OFFICE	52	(PSY)	NIGHT CARE FACILITY	41	(AMB)	AMBULANCE	99	(OMF)	OTHER MEDICAL FACILITY

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED AND PAYMENT IS THEREFORE DUE.

Signature of Provider (including degree or credentials) **Date**

MAIL COMPLETED CLAIM FORM TO:

PacifiCare®
P.O. Box 6019
Cypress, CA 90630-6019