MEMBER REIMBURSEMENT FORM

MEMBER INFORMATION		
Member Name:	Date Submitted:	Member ID #:
Address:		Telephone #:
Patient Name (if different than Member):		DOB:

PROVIDER / SERVICE INFORMATION	
Servicing Provider:	Telephone #:
Clinic or Facility:	Address:
Diagnoses:	Date(s) of Service:
Service(s), Procedure(s), or Item(s) Purchased:	
Charges:	Amount Paid:

DOCUMENTATION REQUIRED: Samaritan Select requires proof that the services were rendered and that the member has paid for these services. Please provide copies of the following:

1. **Provider statement or bill,** showing name of provider, date of service, diagnosis, procedure(s) performed and charges.
2. **Customer receipt or statement** (showing payments applied to your account) or **cancelled check** showing that member has paid for services rendered.
3. If you have other insurance coverage and they are your primary insurance, a copy of their **statement or EOB (evidence of benefits)** is also required.

Claims received by Samaritan Select with incomplete documentation will be returned to the member for completion. Complete claims will be processed within 30 days of receipt.

You may **fax your claim to us at (541) 768-6975 or mail to**:

Samaritan Select
Samaritan Health Plans
P.O. Box 1310
Corvallis, OR 97339