**Please submit claims to:**
Attn: DMR- Medical
CareOregon Advantage Claims Department
315 SW Fifth Ave, Portland, Oregon 97204
Fax #: 503-416-8115

# DIRECT MEMBER REIMBURSEMENT FORM-MEDICAL

*CareOregon Advantage's policy for medical services is to pay the provider and provider is responsible for reimbursing the member. In some cases, when the provider refuses to bill CareOregon, we can reimburse the member up to the allowed amount. We do not reimburse for non-covered services. Member will work with Customer Service to submit bill to CareOregon Advantage. Before submitting this form, please contact CareOregon Customer Service at* 888-712-3258*. Also, check that the information on this form is complete and legible. If the decision for reimbursement is favorable, you will receive a notice and payment within 30 days from the date that we receive the request.*

**To help us process the request, please include the following:**

1. Call Tracking ID number, provided by Medicare Customer Service. Call Tracking ID#_____
2. Proof of payment
3. Itemized bill with the following information:
   - Patient Name
   - Patient health record #
   - Provider name, address, phone number and National Provider Identifier (NPI)
   - Patient account number
   - Date services were rendered
   - Diagnosis/reason for visit
   - Type of services provided (REV/CPT/HCPCS)
   - Charge for each of the services

**Please select reason(s) for request(s):**

□ No Insurance card at the time of service

□ Provider was Out of Area

□ Other:_____

| **1. MEMBER INFORMATION** | | | |
|---|---|---|---|
| Last Name: | First Name: | | DOB: |
| Member ID: | Gender: | Phone: | |
| Address: | City: | State: | ZIP: |
| **2. MEMBER OR AUTHORIZED REPRESENTATIVE COMPLETING THE FORM** □ Same as member above □ Parent/Legal Guardian | | | |
| Name: | | Phone: | |
| Address: | City: | State: | ZIP: |
| **3. MEMBER/AUTHORIZED PERSON COMPLETING THE FORM SIGNATURE** | | | |
| By signing this form below, I certify that all information provided on this form is correct to the best of my knowledge; the services that were rendered were for the CareOregon Advantage member on a date that patient was eligible. I am the member or authorized person completing this form and I authorize release of any pertinent information from the provider that is necessary to expedite the processing of said claim to CareOregon Advantage and I understand that fraudulent acts (including false claims) may be subject to civil or criminal penalties. | | | |
| Signature: | | Date: | |
| **FOR CAREOREGON USE ONLY:** Rec'd:_____ ☐ Provider Paid ☐ Approved ☐ Denied ☐ Cancel/Member Ineligible | | | |
| Eligibility:_____ LOB:_____ Duplicate Claim:_____ Uploaded to OneCo:_____ Other:_____ | | | |