Member Claim Form

Sutter Health Plan

Use this Sutter Health Plan Member Claim Form to ask for payment for eligible care you have already received and paid the provider of service. This includes over-the-counter (OTC) COVID-19 at-home tests you purchased without a prescription at retail pharmacies, grocery stores and online.

Follow the instructions below to file a claim for reimbursement of covered services. Sutter Health Plan may delay or return your claim if information is missing. To ensure your claim is processed appropriately, you must:

- Fill out this entire form if you paid for services. Include all requested documentation (itemized bill, proof of payment).
- Use a separate form for each member you are submitting claims for.
- Confirm with the provider that they have not sent a claim to Sutter Health Plan for your services. Sutter Health Plan rejects duplicate claims, and this may delay payment of the original claim.
- Mail completed form and requested documentation to the address below as soon as possible after you receive care. You must also include any additional information we request.

Please refer to your Evidence of Coverage and Disclosure Form (EOC) for additional details on benefits and reimbursement for services. If you have any questions about how to complete this form, please call Sutter Health Plan Customer Service at **855-315-5800** (TTY 855-830-3500).

Mail your completed form to:

Sutter Health Plan
Attn: Claims Operations
P.O. Box 211314
Eagan, MN 55121

Sutter Health Plan

Section A – Subscriber Information

Subscriber ID Number

Last Name | **First Name** | **MI** | **Date of Birth**

Residential Address | **City** | **State** | **ZIP**

Home Phone | **Mobile Phone**

Section B – Patient Information (If different from subscriber information)

Last Name | **First Name** | **MI** | **Date of Birth**

Member ID Number | **Relationship to Subscriber**

Does the patient have other health insurance coverage?

☐ **Yes** ☐ **No** (If "Yes," please complete all of the information below.)

Name of other health insurance company | **Group Number**

Employer Name | **Policy Number**

Health Insurance Address | **City** | **State** | **ZIP**

Section C – Medical Information

Please include an itemized bill from your provider and proof of payment with this form. Each itemized bill must include:

- Name, address and tax identification number of provider (doctor, hospital, lab, pharmacy)
- Name of the patient
- Description of the service(s) provided
- Date on which the service(s) were provided
- Amount charged for each service
- Diagnosis code for the services provided*
- Procedure code for each of the services*

*Not required for OTC COVID-19 tests.

Section C – Medical Information Cont.

1. **Was this medical expense the result of an accident?** ☐ Yes ☐ No
2. **If yes, is there a third party involved?** Yes No
3. **Was this condition or injury job related?** ☐ Yes ☐ No
4. **Have you filed for Workers' Compensation?** ☐ Yes ☐ No
5. **If yes, when did the injury or accident happen?** Date .....
6. **Did you receive the services while traveling outside of the United States?** ☐ Yes ☐ No
7. **If yes, what dates were you traveling outside of the country?** Dates .....
8. **Is this expense for OTC COVID-19 tests?** ☐ Yes ☐ No

Section D – Agreement

I certify that, to the best of my knowledge, the information on this Member Claim Form is true and correct. I authorize the release of any medical information necessary to process this claim.

Any person who knowingly presents false or fraudulent claims for payment may be guilty of a criminal act punishable under law and may be subject to civil penalties.

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Authorized Signature

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Date

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Printed Name (First and Last)