Member Claim Form

In certain situations a Provider of health care services may not submit your claim directly to Sutter Health Plus (e.g. Emergency Services from a Non-Participating Provider). In these situations you will need to pay the Provider and file a claim for reimbursement (unless the Provider agrees to bill Sutter Health Plus directly).

To file a claim for reimbursement of *covered services*, please follow these instructions closely. Missing information may result in your claim being delayed or returned to you.

- Confirm with the Provider that no claim has been submitted to Sutter Health Plus for these services. Duplicate claims will not only be rejected but may delay payment of the original claim;
- If you have paid for the services, complete this Claim Form in its entirety and include all requested documentation (e.g. itemized bill; proof of payment);
- Use a separate Claim Form for each patient;
- Mail this completed form and requested documentation to the following address as soon as possible after receiving the care. Any additional information we request should also be mailed to this address:

Sutter Health Plus
Attn: Claims Operations
P.O. Box 160385
Sacramento, CA 95816

Please refer to your Evidence of Coverage for additional details on benefits and reimbursement for services. If you have any questions about how to complete this form, please contact Member Services at (855) 315-5800.

IMPORTANT: Can you read this form? If not, we can have somebody help you read it. You may also be able to get this form written in your language. For free help, please call Sutter Health Plus Member Services (855) 315-5800. (English)

IMPORTANTE: ¿Puede leer este formulario? Si no puede, podemos pedir que alguien le ayude a leerla. También es posible obtener este formulario en su idioma. Para recibir ayuda gratuita, llame enseguida al departamento de Servicio a los miembros de Sutter Health Plus al (855) 315-5800. (Spanish/ Español)

Subscriber Information (on Sutter Health Plus Card)			
Subscriber / Member Identification Number:	Group Number:		
Last Name:	First Name:		M.I.
Street address (please include apt. no.):			
City:	State:	Zip:	
Home and/or mobile telephone number:	Date of Birth (MM/DD/YYYY):		
Patient Information			

Sutter Health Plus
We Plus You

Subscriber Information (on Sutter Health Plus Card)					
Last Name:	First Name:		M.I.	Date of Birth (MM/DD/YYYY):	
Member ID number (11 characters):	Does the patient have other health insurance coverage? ☐ Yes ☐ No		Relation to Subscriber: ☐ Self ☐ Spouse ☐ Son ☐ Daughter		Gender: ☐ M ☐ F
Name of other health insurance company:	Group number:	Employer name:		Policy number:	

Medical Information

Please include with this form an **itemized bill** from your Provider along with proof of payment. Each itemized bill must include a minimum of:

- Name, address, and Tax Identification Number of the servicing Provider (doctor, hospital, etc.),
- 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

1) Was this medical expense the result of an accident? ☐ Yes ☐ No
2) Was this condition or injury job related? ☐ Yes ☐ No
3) Have you filed for Workers' Compensation? ☐ Yes ☐ No
4) When did this injury or accident occur? (MM/DD/YYYY) _____

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 claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Authorized Signature | Printed Name (First and Last) | Date