Partnership HealthPlan of California (PHC)

Claims Request Form

MEMBER INFORMATION

PHC Member ID # (99999999A9): _____

Member's Name: _____ _____
First Last

Date of Birth: _____

Mail Claims Information to:

Mail to: _____ _____
First Last

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Please send me copies of claims paid by PHC for services received between the following dates:

From: _____ To: _____

_____ _____
Print Name Signature

_____ _____
Date Relationship to Member
(Parent, Guardian, Conservator, etc.)

Mail or fax your completed form to the attention of the Enrollment Unit:

PHC
4665 Business Center Drive
Fairfield, CA 94534
Fax (707) 863-4415

Mbr Form #68 (MC1175E)
Remark Code M9
Date 04/2016