PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

4665 Business Center Drive
Fairfield, California 94534

Claims Request Form

1. Member Information:

Member's Name: _____ _____
First Last

Date of Birth: _____ Partnership Member ID Number (99999999A9): _____

2. Mail Claims Information to:

Mail to: _____ _____
First Last

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

***To send information to another person, company, agency etc. a release of information form is required.**

3. Send copies of Partnership claims for services received between the following dates:

From: _____ To: _____
(MM/DD/YYYY) **(MM/DD/YYYY)**

4. Your signature:

_____ _____
Print Name Signature

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

5. Mail or fax your completed form to:
Partnership HealthPlan of California
ATTN: Enrollment Unit
4665 Business Center Drive
Fairfield, CA 94534
Fax: (707) 863-4415

Mbr Ltr #68 (MC1172E)
Remark Code M9
DHCS Approval 10/27/2023
PHC-2023-85