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