Medical Claim Form

Member instructions: Complete and sign

PO Box 91110 Sioux Falls, SD 57109 (877) 305-5463 Fax: (605) 328-6811 sanfordhealthplan.com



Member instructions: Complete and sign section one and give to your provider to complete section two.

Submission of this claim form does not guarantee payment of services. Claims may be delayed for missing information. Submit completed form, along with applicable receipts or itemized statements and proof of payment to Sanford Health Plan at the address above.

ity:					Subscriber I.D. Number:					
•		Patient's Address:				Subscriber's Name:				
in Code	City:			Subscriber's Address:						
ip Code:	Telephone:		City:	City:			State:			
atient's Birth Date: Gender:	Patient Relationsl F □ Self □ Spous	-	Zip Code Other	Zip Code		Telephone:				
ubscriber's Employer:			Are services for	a work related i	njury?					
atient's or Authorized Person's Sig authorize the release of any medical or o igned		ry to process this clai	☐ Yes ☐ No  Date Signed:							
ate of Accident:	Referring Phy	sician NPI:								
viagnosis Code:										
				D H						
					1 L					
Dates of Service: From: To: IM DD YY MM DD Y	Of Comice	edures, Services, or Supplies HCPCS Modifier	Description of Service	s Diagnosis Pointer	Charges	Days or Units	Rendering Provider I.D. Numb			
Federal Tax I.D. Number SSN EIN		Patient's Account No.:		Total Char	Total Charge:					
ignature of Physician or Supplier in egrees or credentials:		e Facility Location	Information:	Billing Pro	vider Info ar	nd Phone	Number:			
igned		y NPI:		Billing NP	r.					