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

SANFORD HEALTH PLAN

Medical Claim Form

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.

SECTION 1

Subscriber and Patient Information

Patient's Name:		Subscriber I.D. Number:	
Patient's Address:		Subscriber's Name:	
City:	State:	Subscriber's Address:	
Zip Code:	Telephone:	City:	State:
Patient's Birth Date:	Gender: ☐ M ☐ F	Patient Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other	Zip Code / Telephone:
Subscriber's Employer:		Are services for a work related injury? ☐ Yes ☐ No	
Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process this claim Signed_____		Date Signed:	

PATIENT AND INSURED INFORMATION

SECTION 2

Date of Accident:	Referring Physician NPI:

Diagnosis Code:

A. _____ B. _____ C. _____ D. _____

E. _____ F. _____ G. _____ H. _____

I. _____ J. _____ K. _____ L. _____

Dates of Service: From: MM	DD	YY	To: MM	DD	YY	Place Of Service	Procedures, Services, or Supplies CPT/HCPCS	Modifier	Description of Services	Diagnosis Pointer	Charges	Days or Units	Rendering Provider I.D. Number

Federal Tax I.D. Number SSN ⊙ EIN ○	Patient's Account No.:	Total Charge:
Signature of Physician or Supplier including degrees or credentials: Signed_____ Date_____	Service Facility Location Information: Facility NPI:	Billing Provider Info and Phone Number: Billing NPI:

PHYSICIAN OR SUPPLIER INFORMATION