ATRIO Direct Member Reimbursement
(Medical Claims Only)

Thank you for choosing ATRIO Health Plans for your health insurance coverage. Use this claim form for any reimbursement requests you may have. If you received services from a contracted provider, your claim should be submitted by the provider; therefore you do not need to submit this form unless you know that your claim was not submitted. Please complete a separate form for each member or provider.

Instructions

1. Complete the form on the following page.
2. Attach original proof of payment or provider bill to page 3 of this form. Cash register receipts will not be accepted. Please retain copies of proof of payment for your records, as the original will not be returned.
3. Sign the completed form where indicated
4. Submit the completed form(s) and proof of payment in one of the following ways:

Mail ATRIO Health Plans P.O. Box 8030 Kalispell, MT 59904		**Fax** 866-298-8412 **Email** CustomerService@atriohp.com	
Deliver To ATRIO Health Plans 2270 NW Aviation Drive Suite 3 Roseburg, OR 97470	ATRIO Health Plans 810 O'Hare Parkway Suite B Medford, OR 97504	ATRIO Health Plans 4509 S. 6th Street Suite 305 Klamath Falls, OR 97603	ATRIO Health Plans 2965 Ryan Drive SE Salem, OR 97301

Be sure to include appropriate documentation of payment. Incomplete forms submitted without the necessary information and documentation may result in a delay in your reimbursement or may be returned for additional information. Reimbursement form must be received no later than one year after the date you paid for the service.

ATRIO HEALTH PLANS

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Member Information

Member Name:		Gender: ☐ Male ☐ Female
Member ID #:		DOB:
Phone #:		
Address:		
City:	State:	Zip:
Please indicate why you paid out of pocket for this service: **(Continue to next page)**		

I certify that the above statements are correct and hereby authorize any physician, hospital or provider to supply ATRIO Health plans any information required in connection with this claim. A photocopy of this authorization shall be as valid as the original.

Member Signature: _____ Date: _____

Medical and Vision Bills must contain:

- Providers name and address
- Diagnosis code
- Procedure code
- Date of service
- Itemized charges

Contact the Provider if you need additional information. Claims will be processed and reimbursed within 30 days.

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Attach Proof of Payment Here