Claims-Related Documents Provider Form

Please use this form if you are sending us additional information regarding an individual claim (e.g., medical records, itemized bills- full list of possible documents below). Please do not use this form if you are disputing a claim or appealing an authorization. If you want to submit a claims dispute or clinical appeal, please use the "**Claims Disputes** Provider Form" or "**Clinical Appeals** Provider Form".

Provider information		
First name	Last name	
Provider NPI	Group NPI	Provider TIN
Facility / Group Name	Are you contracted with Oscar? ◯ Yes ◯ No	
Contact phone #	Contact fax #	

Member information (one member only)	
First name	Last name
DOB	Member Oscar ID (OSC#xxxxxxxx-xx)

Claim information, if post-service (one claim ID only)		
Oscar claim ID	DOS Start	DOS End
Billed amount	Procedure code(s)	

What type of document is attached to this cover sheet? (Select one option that best describes the document)	
◯ Medical Record (*if applicable, please also select one option if you are responding to a medical record request from the following):* ◯ HEDIS ◯ Risk Adjustment ◯ Quality	
◯ Check	◯ Signed offset Overpayment Consent Letter
◯ Single Case Agreement	◯ Itemized bill
◯ Acquisition Invoice	◯ EOP for another payor other than Oscar
◯ Claim overpayment refund; Refund check is attached: ◯ Yes ◯ No	◯ HMO-related document ◯ Post denial referral request
◯ Member-related document ◯ Authorization to disclose Protected Health Information ◯ Proof of qualifying event ◯ Care navigator / coordinator request (e.g. nonpar provider referral request) ◯ Other	◯ Other (please specify):

Explanation (please explain your reason for submitting this document)

Please send your completed form and supporting documentation via one of the following methods:

- Fax: 1-888-977-2062
- Mail: Oscar Health, Inc. P.O. Box 52146 Phoenix, AZ 85072–2146.
- Mailed overpayment refunds: Oscar Health, ATTN: Provider Refunds, 615 S. River Drive, Tempe, AZ 85281.