



**TotalCare**<sup>SM</sup>  
HMO D-SNP



## Claim Attachment Submission Form

This form is only to be used when submitting documentation associated with claims already submitted. Complete the form and fax or mail the form to the address/number provided at the bottom of the page. Complete one (1) submission form for each claim for which documentation is being submitted. This form should not be submitted prior to filing the claim. Faxed documentation must be received within 7 days of the claim and mailed documentation must be received within 10 days of the claim

### Please complete all fields

ACN (as entered in the PWK loop on the claim) \_\_\_\_\_

ICN/Patient Acct Number \* \_\_\_\_\_

Member Last Name: \_\_\_\_\_ Member First Name: \_\_\_\_\_

Member ID: \_\_\_\_\_

Date of Service: \_\_\_\_\_ Total Claim Billed Amount: \_\_\_\_\_

Billing Provider's Name: \_\_\_\_\_

Contact's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

NPI: \_\_\_\_\_ Total Number of Pages (including cover sheet): \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Print and Return Completed Form and Documentation by:

Fax: **831-430-5858**

Mail: CCAH

1600 Green Hills Rd. #101

Scotts Valley, CA 95066