

Member Reimbursement Form



1231 East Beltline NE, Grand Rapids, MI 49525-4501 | Fax: 616 942-0616

Please fully complete the form, printing clearly, sign and date.

- If submitting claims for more than one family member, complete a new form for each person.
- Submit an itemized statement for each medical expense, including:
 - Name of patient
 - Provider of service
 - Diagnosis and description of service
 - Date(s) of service
 - Amount of charge for each service

SECTION 1 - MEMBER INFORMATION

Contract Number (with suffix)	Member Name		
Address	City	State	Zip

SECTION 2 - COMMENTS (optional)

Description / Explanation of claim or receipt:

SECTION 3 - SIGNATURE

The above statements and attachments are true and complete to the best of my knowledge.

X _____
Signature Date

SECTION 4 - INSTRUCTIONS

Fax to: 616 942-0616 to expedite handling.

If unable to fax - Mail to:

Priority Health
ATTN: Claims Department
P.O. Box 232
Grand Rapids, MI 49501-0232

Questions?
Call Customer Service
800 446-5674 or
616 942-1221