Member reimbursement form

PriorityHealth

Please print clearly. Remember to sign and date this form before sending.

- **If submitting claims for more than one family member**, complete a new form for each person.
- **Medical expenses**: Include an itemized receipt or other proof of payment for each medical expense. It must show:
  - Name of patient
  - Provider of service
  - Diagnosis and description of service
  - Date(s) of service
  - Amount charged for each service
  - Notation showing the charges were paid
- **Prescription expenses**: Include a receipt for each prescription purchase. It must show:
  - Date prescription filled (date of service)
  - Name and address of pharmacy
  - Doctor name or ID number
  - Name and NDC (National Drug Code) number of the medication
  - Quantity and days' supply
  - Prescription number (RX number)
  - Amount paid
  - Notation showing the charges were paid

SECTION 1: PATIENT INFORMATION

Member ID number (on your membership card)	Member name	Member date of birth	
Street address	City	State	ZIP
Phone number that we may use you contact you ☐ Landline (home phone) ☐ Cell phone		Alternate number that we may use to contact you *(optional)* ☐ Landline (home phone) ☐ Cell phone	

SECTION 2: COMMENTS (OPTIONAL)

Description/explanation of claim or receipt:

continued>

SECTION 3: SIGNATURE

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

Signature _____ Date _____

SECTION 4: INSTRUCTIONS

Fax to 616.942.0616 for quickest processing.

If unable to fax, **mail** to:
Priority Health
ATTN: Claims Department
P.O. Box 232
Grand Rapids, MI 49501-0232

Questions?
Call Customer Service at the phone number on the back of your Priority Health membership card.

SECTION 5: ADDITIONAL PRESCRIPTION CLAIM INSTRUCTIONS

1. Always present your prescription drug membership card at the pharmacy.
2. You must complete a separate claim form for each patient.
3. You must submit claims within one year from the date of service.
4. **Be sure your receipts are complete.**

To process your request, we need all receipts to contain the information listed at the top of this form. If needed, your Pharmacist can provide you with the necessary information.

Coordinating payment with your other insurance

You must first submit the claim to your primary insurance plan. Once you have received a statement (sometimes called an Explanation of Benefits or Claim Activity Statement) from the primary plan, complete this form. Be sure to include the original prescription receipt(s) along with the statement from the primary plan, which clearly indicates the cost of the prescription and what was paid by the primary plan. If you pay a copayment or coinsurance at the retail pharmacy under your primary plan's coverage, then no statement is needed. Just complete this form and attach the prescription receipt(s) that shows the copayment or coinsurance amount you paid at the pharmacy. The receipt will serve as the Claim Activity Statement (CAS).