

HSA Member Deductible Credit Request



1231 East Beltline NE • Grand Rapids, MI 49525-4501 • Fax: 616 942-0631

Before completing this form, please check with your employer. You are eligible for this credit only:

- if your benefit plan year has changed to begin on January 1st, and
- if you had an HSA with a high deductible health plan previously and are switching to Priority Health's HSA with a high deductible health plan.

Section 1 - Member information (contract number and group number are located on your Priority Health ID card)			
MEMBER NAME (LAST & FIRST)	CONTRACT NUMBER (WITH SUFFIX)	GROUP NUMBER	
MEMBER ^a ADDRESS	CITY	STATE	ZIP CODE

Section 2 - Instructions

If you already met part of this year's deductible with your previous health plan, you don't have to start over. Complete this form to get credit toward your Priority Health deductible.

Complete a separate HSA Deductible Credit Request form for each member in your family.

Attach the most recent Explanation of Benefits (EOB) that you received from your previous health plan for each family member. The EOB must show the total deductible each family member has met during this calendar year. Please paperclip the Explanation of Benefits to the upper left-hand corner of this document. (Please do not staple.)

Only the deductible met from your previous insurance company will be taken into consideration (any additional out-of-pocket maximum amounts met with the previous carrier will not be credited). Credit given toward the current Priority Health plan will max-out at the current medical plan deductible amount. We will accept your forms up to 120 days after your Priority Health plan became effective. Your deductible credit amount(s) will apply to services received in-network only.

Section 3 - Former health plan and Explanation of Benefits (EOB)

NAME OF YOUR FORMER INSURANCE COMPANY _____

The plan was an HSA-qualified high deductible health plan, meaning that the high deductible health plan was combined with a health savings account as permitted by the Internal Revenue Service.

The EOB must contain the following:

- Name of previous insurance company
- Patient name
- Date of service
- Total deductible met from your previous plan since January

Section 4 - Member comments

Section 5 - Signature

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

Employee signature _____ Date _____

Mail to: Priority Health, Attn: Claims Dept.
P.O. Box 232
Grand Rapids, MI 49501-0232

Or fax to: 616 942-0616

Questions? Call Customer Service at 800 389-6646 or 616 464-8810