

SECTION 1 - INSTRUCTIONS

To help expedite claim processing, please fully complete this form and sign "Authorization" in Section 8.

- Please print clearly to avoid delays in your payment.
- Complete a claim form for each illness or injury. When submitting claims for more than one family member, complete a claim form for each person.
- Submit itemized statement for each medical expense. Itemized statements must include name of patient, provider of service, diagnosis, description of service, date(s) of service, and amount of charges for each service.
- Patient or guardian must sign the authorization to obtain or release information for use in processing your claim.
- Mail claims to: Priority Health Managed Benefits
Attention: Claims
PO Box 232
Grand Rapids, MI 49501-0232

SECTION 2 - WHERE TO CALL WITH QUESTIONS

Customer Service - Self-Funded: 800 956-1954 / Fully-Funded; 800 446-5674

SECTION 3 - EMPLOYEE INFORMATION

Employee Last Name	First Name	Middle Initial	Contract Number
Employee/ Company Name			Group Number

SECTION 4 - PATIENT INFORMATION

Patient Name	Relationship to Employee
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SECTION 5 - OTHER INSURANCE INFORMATION

Is the patient covered by Medicare or any other insurance policy? Yes No If yes, complete this section.

WHERE ARE CLAIMS SENT?	Company Name	Company Address			
POLICY HOLDER INFORMATION	Name of Policyholder	Social Security Number	Birthdate / /	Policy Effective Date / /	Employer
	Other Family member(s) Covered by this Policy				
REASON FOR MEDICARE	(1) _____ (2) _____ (3) _____ (4) _____				Effective Date / /
	End Stage Renal Disease <input type="checkbox"/>	Disabled <input type="checkbox"/>	Over Age 65 <input type="checkbox"/>	Over Age 65 and Working <input type="checkbox"/>	

SECTION 6 - ACCIDENT REPORT

If this care is the result of an accident, please complete this section.

Was this accident:

Sports Related <input type="checkbox"/>	Work Related <input type="checkbox"/>
Slip and Fall <input type="checkbox"/>	School Related <input type="checkbox"/>
Auto Related <input type="checkbox"/>	Auto Related, please attach a copy of your auto insurance policy.
Other (please specify) <input type="checkbox"/>	_____

SECTION 7 - EMERGENCY REPORT

If you had emergency medical services, please complete this section.

Describe circumstances of illness or injury in detail:

SECTION 8 - AUTHORIZATION

Please sign here to avoid delay in claim processing.

I authorize a person or entity involving my medical care or having information regarding my medical care to release information to Priority Health or the Plan Administrator. I authorize Priority Health to release such information, as necessary, to insurance companies, reinsuring companies, organizations performing services in connection with my claim, or as may be otherwise lawfully required, or as I may further authorize. I have the right to request a copy of this information and agree that photocopies of this authorization will be valid.

X _____ / /
Signature of Patient or Legal Guardian Date