Priority Health Medicare
Member Reimbursement Form

PriorityHealth®

Section 1: Member information

Member last name	First name	M.I.	Contract number

Street address	City	State	ZIP code

Do you have coverage with another insurance carrier? ☐ Yes ☐ No If yes, call Customer Service at the number below.	Date of birth	Sex

Section 2: Type of claim

☐ Medical (skip section 4 below) ☐ Prescription
☐ Vaccine only ☐ Vaccine and injection ☐ Injection only

Section 3: Instructions

Please affix your claim/receipt securely to the upper left hand corner of this document (please do not staple). For prescriptions, please also include the duplicate label.

Section 4: Required information for processing claim

Your claim receipt must contain the following information in order to be processed for payment. If all of the necessary information is not submitted, your claim cannot be processed and will be denied for missing information.

- Pharmacy name, address, phone (if applicable)
- Date of service
- Medication quantity
- Days supplied
- National Drug Code (NDC) or drug identifier
- Medication name, strength and form (i.e. Plavix 75mg tablets)
- Prescriber full name
- Total amount paid for medication

Section 5: Comments

Description/explanation of claim:

Section 6: Signature

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

X _____

Signature Date

Please note: Claim submission is not a guarantee of payment. This form covers only drugs obtained within the United States and its territories.

Mail or fax prescription claims to:
Argus Health Systems
Attn: Dept 369/370
P.O. Box 419019
Kansas City, MO 64141
Fax: 816 843-6415

Mail medical claims to:
Priority Health
P.O. Box 232
Grand Rapids MI 49501
Attn: Priority Health Claims

Questions?
Call Customer Service at 616 464-8820 or toll-free 888 389-6648
TTY/TDD 616 464-8485 or toll-free 888 551-6761
8:00 a.m. - 8:00 p.m., 7 days a week