PriorityHealth®
1231 East Beltline NE
Grand Rapids, MI 49525-4501

MEMBER REIMBURSEMENT FORM

SECTION 1 - MEMBER INFORMATION

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

SECTION 2 - MEDICAL CARE EXPENSES (Supporting Documentation Must Be Attached)

Please affix your claim / receipt securely to the ***UPPER LEFT-HAND CORNER*** of this document. (Please do not Staple)

SECTION 3 - COMMENTS

Description / Explanation of claim or receipt (optional):

SECTION 4 - SIGNATURE

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

Signature: _____ Date: _____

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

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