

# PriorityHRA<sup>SM</sup> Health Reimbursement Arrangement (HRA)



## WITHDRAWAL REQUEST

MS 2260  
1231 East Beltline NE • Grand Rapids, MI 49525-4501 • Fax: 616 942-0631

SECTION 1 - MEMBER INFORMATION			
MEMBER NAME		CONTRACT NUMBER (WITH SUFFIX) & SOCIAL SECURITY NO.	
ADDRESS	CITY	STATE	ZIP CODE

SECTION 2 - INSTRUCTIONS
Please submit documentation to support your reimbursement request.

SECTION 3 - REIMBURSEMENT REQUEST	
Please reimburse: <ul style="list-style-type: none"> <li><input type="checkbox"/> Coinsurance - attach your Priority Health EOB</li> <li><input type="checkbox"/> Contraceptive Management Expense - attach prescription receipt from pharmacy (not register receipt)</li> <li><input type="checkbox"/> Brand Name Rx Copayment - attach prescription receipt from pharmacy (not register receipt)</li> <li><input type="checkbox"/> Deductible - attach your other health plan EOB</li> <li><input type="checkbox"/> Other</li> </ul>	Amount Requested
*EOB - Explanation of Benefits Not all of the above options are available to all employer groups. Submit your withdrawal request for the option(s) offered by your employer only.	

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. 1231 E. Beltline MS2260 Grand Rapids, MI 49501-0232	QUESTIONS? Call Customer Service number on your ID card