

# Priority Health Medicare Medical reimbursement form

## Section 1: Member information

Last name	First name	MI	ID number
Street address	City	State	ZIP code
Do you have coverage with another insurance carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, call Customer Service at the number below.		Date of birth	Sex

## Section 2: Instructions

Please affix your claim/receipt securely to the upper left hand corner of this document (please do not staple).

## Section 3: Comments

Reason treatment was required/explanation of services:

## Section 4: Signature

The above statements and attachments are true and complete to the best of my knowledge. If someone is submitting the claim on the patient's behalf, an Authorization of Representation form (Form CMS-1696) must be attached. Form CMS-1696 can be downloaded at [priorityhealth.com](https://www.priorityhealth.com) or obtained by calling the Customer Service number on the back of your membership card.

X \_\_\_\_\_  
Signature Date

**Please note:** Claim submission is not a guarantee of payment.

### Mail medical claims to:

Attn: Priority Health Claims  
Priority Health  
P.O. Box 232  
Grand Rapids MI 49501

### Questions?

Call Customer Service toll-free at 888.389.6648, TTY 711  
8:00 a.m.–8:00 p.m., seven days a week