Priority Health

Priority Health reimbursement form

For out-of-country health care expenses

Please complete this form and attach a copy of your receipts.
If you have claims for more than one family member, complete a new form for each person.

Section 1 – Member information

Priority Health contract number	Last name		First name
Street address	City	State	ZIP code

Section 2 – Health care expenses

Services received	Provider	Reason for visit	Date of service	Currency type billed (Example: Peso, Euro, etc.)	Amount charged (in U.S. dollars)
				Total:	

Section 3 – Additional information

Did you have travel insurance? ☐Yes ☐No

If yes:

Name of the travel insurance carrier: _____

Travel policy contract number: _____

Travel insurance carrier phone number: _____

Was any of the travel work related? ☐Yes ☐No Explain: _____

In what country did these expenses take place? _____

Is this reimbursement related to an accident or injury? ☐Yes ☐No

If yes:

How did the injury take place? _____

Was a vehicle involved? ☐Yes ☐No

Where did it take place? _____

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Section 4 – Comments (optional)

Section 5 – Signature

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

Signature	Date

Section 6 – Instructions

Fax to: 616.942.0616
Or mail to:
Priority Health
Attn: TPL Department, MS 2205
P.O. Box 232
Grand Rapids MI 49501-0232

Questions?
Call Customer Service toll-free at 800.446.5674 (TTY users should call 711), seven days a week.
Monday-Thursday: 7:30 a.m. to 7 p.m.
Friday: 9 a.m. to 5 p.m.
Saturday: 8:30 a.m. to noon