



Dear Member,

Please use this form to apply for reimbursement when you pay for a medical service or prescription. This is not a guarantee of payment. All HealthPlus rules of coverage will be applied when evaluating the eligibility of your claim. Please fill out the form as completely as possible. Incomplete information may delay your payment or result in non-payment. If you need assistance obtaining the required information, contact the provider of the service you received. Please allow 4-6 weeks for your claim to be processed.

Instructions:

1. Claims should be submitted within one year of the date of service.
2. Complete this form and **include the insured's signature at the bottom of the page.**
3. Attach documentation of services received. If documentation is not attached, your claim will not be processed. **For medical reimbursement**, you must attach your itemized statement along with proof of payment. **For prescription reimbursement**, you must attach your original prescription receipt. This is different from your cash register receipt and is typically stapled to your prescription bag.
4. Complete a separate form for each family member and each pharmacy.
5. You can make copies of this form for future use or you can print a copy from the HealthPlus website at www.healthplus.org.
6. Make a photocopy of the form and receipts for your personal records.
7. Return the completed and signed form to:

HealthPlus of Michigan
Attn: Customer Service Dept.
PO Box 1700
Flint, MI 48501-1700

If you have any questions, a Customer Service Representative is available to assist you Monday through Friday, 8 a.m. to 8 p.m. Call 1-800-332-9161 (TDD number is 1-800-992-5070).

Sincerely,

HealthPlus Customer Service

Request for Reimbursement Form

Original receipt required.



Patient name		HealthPlus 11-digit ID number, including suffix		
Address		City	State	Zip
Date of birth ____/____/____	Home phone number (____)____-____		Work phone number (____)____-____	
Medical (Payment will be made to member at cardholder address unless otherwise specified on the next page.*)				
Date of service	Procedure code	Diagnosis code	Amount charged	Amount paid
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Where was service performed?				
<input type="checkbox"/> Doctor's office <input type="checkbox"/> After-hours clinic <input type="checkbox"/> Group clinic/facility <input type="checkbox"/> Emergency room <input type="checkbox"/> Hospital				
Name of doctor, clinic or hospital where service was performed			Tax ID number	
Doctor, clinic or hospital address			Phone number	
Do you have any other health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please list company and contract or group number		
Briefly describe what caused you to pay out-of-pocket? (Required)				

***Please complete the other side of this form if applicable
and sign at the bottom where indicated. Thank you.***

Prescription (Payment will be made to the cardholder unless otherwise specified below.)*

Pharmacy name and address			Pharmacy phone number (_____) _____ - _____		
Date of service	Prescription number	Drug name and strength	Quantity	Day supply	Amount paid
National Drug Code (11-Digit)		Prescribing physician (first and last name)		Prescribing physician's address	
Date of service	Prescription number	Drug name and strength	Quantity	Day supply	Amount paid
National Drug Code (11-Digit)		Prescribing physician (first and last name)		Prescribing physician's address	
Do you have any other prescription coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please list contract or group number			
**Briefly describe what caused you to pay out-of-pocket? (Required)					
<i>If reimbursement needs to be made to an address other than the cardholder's, please provide the name and address of where you prefer to have payment sent:</i>					
Name _____					
Address _____ City _____ State _____ Zip _____					
<i>Please sign below</i>					
<i>The service(s) and/or medication(s) described on this form and for which payment is being requested has been received. I certify that the information provided is correct and authorize the release of all information contained on this form.</i>					
Signature _____					Date _____

****Members should use network pharmacies to access their prescription drug benefit.**