

REQUEST FOR REIMBURSEMENT

Original receipt required. Please read and sign page 2 of this form.

Patient Name		HealthPlus member/subscriber number	
Address		City	State ZIP
Date of Birth	Home Telephone Number ()	Work Telephone Number ()	

MEDICAL PAYMENT WILL BE MADE TO MEMBER AT CARDHOLDER ADDRESS UNLESS OTHERWISE SPECIFIED BELOW *

Date of Service	Procedure Code	Diagnosis Code	Amount Billed	Amount Paid

Where was service performed?
 Doctor's office After Hours Clinic Group Clinic/Facility Emergency Room Hospital

Name of Doctor, Clinic or Hospital where service was performed	Tax identification number
Doctor, Clinic or Hospital address	Telephone number

Do you have any other health insurance?
 Yes No If yes to other insurance, please list company and contract or group #

Briefly describe what caused you to pay out-of-pocket (**Required**):

PHARMACY PAYMENT WILL BE MADE TO CARDHOLDER UNLESS OTHERWISE SPECIFIED BELOW *

Pharmacy Name and address				Pharmacy Telephone Number	
Date of Service	Prescription Number	Drug Name and Strength	Quantity	Days Supply	Amount Paid

Prescribing Physician (First and last name)	Prescribing Physician's Address
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Do you have any other prescription coverage?
 Yes No If yes to other prescription coverage, please list contract or group # here

Briefly describe what caused you to pay out-of-pocket (**Required**):

* 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:

Name _____
 Address _____ City _____ State _____ ZIP _____

Date _____

Dear Member:

Please use this two-page 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 90 days of the date of service.
2. Complete both pages of this form and include the insured's signature at the bottom of this page.
3. Attach documentation of services received. **If documentation is not attached, your claim will not be processed.** 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. FOR MEDICAL REIMBURSEMENT: You must attach your **itemized statement** along with proof of payment.
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 Web site at www.healthplus.com
6. Make a photocopy of the form and receipts for your personal records.
7. Return the completed and signed form to:

HealthPlus
Attn: Customer Service Dept.
P.O. Box 1700
Flint, MI 48501-1700

If you have any questions, a Customer Service Representative is available to assist you Monday through Friday, from 9 a.m. to 6 p.m. HMO and POS members, please call 1-800-332-9161. PPO members, please call 1-888-212-1512. The number for the telephone for the deaf is 1-800-992-5070.

Sincerely,
Customer Service Department

Please complete both pages of this form and sign below:

I certify that the medication or service described and for which payment is requested has been received. I certify that the information provided is correct and authorize the release of all information contained on both pages of this form.

Signed _____ Date _____

Insurance fraud can significantly increase the cost of health care. If you are aware of any false information submitted to HealthPlus, you can help us lower these costs by calling our toll-free compliance hotline. You do not need to identify yourself. COMPLIANCE TOLL-FREE HOTLINE: 1-800-345-9956.