

**STATEMENT OF MEDICAL CLAIMS**

**Questions? Contact Customer Service**  
**M-F 8:30 a.m. to 5:30 p.m.**  
**Phone 833.484.8450**  
**Or by fax 517.364.8411**

**WHEN COMPLETED RETURN TO:**  
**PHP Service Company**  
**P.O. Box 30377**  
**Lansing, MI 48909-7877**

**A. INSTRUCTIONS: MEDICAL REIMBURSEMENT REQUEST**

To request a refund, please complete this form in its entirety. In order for your request to be reviewed, you MUST also include an itemized receipt from the provider that displays the date of service, the total billed amount for each service, procedure code for each service, diagnosis code and proof of payment. Please keep a copy of your original documents. For claims within the U.S.A, please allow 4-6 weeks for processing. We want to make sure that you are aware that reimbursement checks are always written out to the subscriber.

**TO BE COMPLETED BY INSURED****B. INSURED (SUBSCRIBER) INFORMATION**

1. Insured(Subscriber)'s Name				
Residence Address		Apt. No.	City	State
2. Telephone		3. Marital Status		
4. Employer		5. Spouse's Name		
6. Name and address (city) of spouse's employer (if employed)				

**C. PATIENT INFORMATION**

7. Patient's Name		7a. Telephone		
8. Patient's Date of Birth	9. Patient's Relationship to Employee		10. Michigan Care ID Number (stated on ID card)	
11a. Provider Name		11b. Date of Service		
*Provider Tax ID#	11c. Was this due to an auto accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		11d. Was this due to a dental injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	
*Procedure Code	11e. If injury, was it job related? <input type="checkbox"/> Yes <input type="checkbox"/> No		11f. Was this an emergency? <input type="checkbox"/> Yes <input type="checkbox"/> No	
*Diagnosis Code	(Please explain)			
*NDC-if reimbursement is for a drug.	12a. Do you or any members of your immediate family have any other group insurance that may cover all or part of this claim?      Yes      No			
*You may obtain this information from the provider. This information is required to process your claim. Processing may be delayed if this information is not provided.	12b. If yes, give insurance company name, address, and group number.			

**D. AUTHORIZATION**

I certify that the above statements are true and correct to the best of my knowledge and hereby authorize any physician, hospital, employer, union, insurance company, HMO or prepayment organization to supply each other any information required in connection with this claim. A photocopy of this authorization shall be valid as the original.

**X**

Insured's Signature	Date Signed
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**E. FRAUD WARNING**

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

