STATEMENT OF MEDICAL CLAIMS

Questions? Contact Customer Service
Monday-Friday, 8:30 a.m. to 5:30 p.m., EST
Phone: 800.832.9186 or 517.364.8500
Fax: 517.364.8411

WHEN COMPLETED RETURN TO:
Physicians Health Plan
PO 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.

TO BE COMPLETED BY INSURED

B. INSURED (SUBSCRIBER) INFORMATION

1. Insured's Name

Residence Address	Apt. No.	City	State	Zip

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. Subscriber ID# (stated on ID card)

11a. Provider Name	11b. Date of Service	
*Provider Tax ID#	11c. Was this due to an auto accident? ☐ Yes ☐ No	11d. Was this due to a dental injury? ☐ Yes ☐ No
*Procedure Code	11e. If injury, was it job related? ☐ Yes ☐ No	11f. Was this an emergency? ☐ Yes ☐ 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

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.