McLaren HEALTH ADVANTAGE

McLaren HEALTH PLAN COMMUNITY

Standard Direct Member Reimbursement Form

Please fill out this form completely. Services will be reimbursed at the benefit level and at McLaren Health Plan's reimbursement amount. You may not receive reimbursement for the full amount you pay out-of-pocket.
If services require authorization, they must be authorized prior to requesting reimbursement or your request will be denied.
Note: You should not be paying a contracted McLaren provider out-of-pocket for services, except for your applicable co-pays, coinsurance, or deductible.

Proof of payment MUST be included with this form for consideration.

Patient Name:________________________________ Member ID: ______________________________

Subscriber Name:____________________________ Phone Number: ____________________________

Address: ____
Street City State ZIP

Medical Services (Office visits, Physical Therapy, Chiropractor, DME etc.)

Provider Name:______________________________ Provider Tax ID: ____________________

Date of Service:_____________________________ Amount Paid: ______________________

Diagnosis:__________________________________ Procedure Codes: ____________________

Note: Attach all documentation provided by the office showing services, diagnosis, and charges.

Pharmacy Services (Prescriptions)

Pharmacy Name: ____

Date Prescription Filled: ____

Medications: __________________________ ____

__________________________ ____

Signature:____ Date: _____________________

Please mail, fax or email completed form along with proof of payment to:
McLaren Health Plan Community/McLaren Health Advantage
Attention: Customer Service Manager
G-3245 Beecher Road
Flint, MI 48532
Fax: 833-540-8648
Email: CustomerService@McLaren.org