McLaren HEALTH ADVANTAGE

McLaren HEALTH PLAN COMMUNITY

Direct Member Reimbursement Form

Please fill out this form completely. Services will be reimbursed at the benefit level and at McLaren'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