Automatic bill payment enrollment form for Medicare plans

I authorize Priority Health to deduct my premium payment from the checking or savings account listed below. By choosing this option, I understand I will not be mailed a monthly invoice. This form must be received by Priority Health by the 25th day of the month to be effective on the first of the upcoming month. I understand the deduction will occur on the first of each month. If at any time I decide to discontinue this payment service, I will notify Priority Health in writing 30 days before discontinuing.

Policy holder name (please print): ______________________________

Priority Health contract number: ______________ Group number: ______________

Financial info:

Account holder name(s): ______________________________

Name of financial institution: ______________________________

Account type: ☐ Checking ☐ Savings

ABA/routing number: ______________________________

Account number: ______________________________

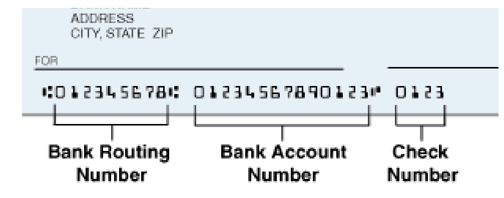
NOTE: If your bank account does not have sufficient funds to cover your plan's premium payment, Priority Health reserves the right to charge a non-sufficient funds (NSF) fee up to the amount allowed by the state of Michigan, which is $25.

Authorized signature: ______________________________

Date: ______________________________

To find your routing number use the 9 digits on bottom left-hand corner of a check, or call your financial institution.

Example:



Please return this form to:
Priority Health, MS 1190
1231 East Beltline NE
Grand Rapids, MI 49525

Or email to:
PH-SMPM@priorityhealth.com

Priority Health has HMO-POS and PPO plans with a Medicare contract. Enrollment in Priority Health Medicare depends on contract renewal.

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