Priority Health

Priority Health Medicare reimbursement form

For out-of-country health care expenses

Please complete this form and attach a copy of your receipts.
If you have claims for more than one family member, complete a new form for each person.
Please note: Part D prescription drugs are not covered outside of the United States.

Section 1 - Member information

Priority Health contract number	Last name		First name
Street address	City	State	ZIP code

Section 2 - Health care expenses

Services received	Provider	Reason for visit	Date of service	Currency type billed (Example: Peso, Euro, etc.)	Amount charged (in U.S. dollars)
				Total:	

Section 3 - Additional information

Did you have travel insurance? ☐Yes ☐No

If yes:

Name of the travel insurance carrier: _____

Travel policy contract number: _____

Travel insurance carrier phone number: _____

Was any of the travel work related? ☐Yes ☐No Explain: _____

In what country did these expenses take place? _____

Is this reimbursement related to an accident or injury? ☐Yes ☐No

If yes:

How did the injury take place? _____

Was a vehicle involved? ☐Yes ☐No

Where did it take place? _____

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Section 4 - Comments (optional)

Section 5 - Signature

The above statements and attachments are true and complete to the best of my knowledge. If someone is submitting the claim on the patient's behalf, an Authorization of Representation form (Form CMS-1696) must be attached. Form CMS-1696 can be downloaded at ***priorityhealth.com*** or obtained by calling the Customer Service number on the back of your membership card.

Signature	Date

Section 6 - Instructions

Fax to: 616.942.0616
Or mail to:
Attn: Priority Health Claims
Priority Health
P.O. Box 232
Grand Rapids MI 49501

Questions?
Call Customer Service toll-free at 888.389.6648 (TTY users should call 711), seven days a week from 8 a.m.–8 p.m.

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