Priority Health Medicare Medical reimbursement form

Section 1: Member information

Last name	First name	MI	ID number
Street address	City	State	ZIP code
Do you have coverage with another insurance carrier? ☐ Yes ☐ No If yes, call Customer Service at the number below.		Date of birth	Sex

Section 2: Instructions

Please affix your claim/receipt securely to the upper left hand corner of this document (please do not staple).

Section 3: Comments

Reason treatment was required/explanation of services:

Section 4: 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.

X _____

Signature Date

Please note: Claim submission is not a guarantee of payment.

Mail medical claims 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 711
8:00 a.m.–8:00 p.m., seven days a week

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