HAP SENIOR PLUS
Pharmacy Reimbursement Form For Medicare Part D

Please complete and return this form with the requested information to:
HAP Senior Plus
Attn: Pharmacy Care Management
2850 W. Grand Boulevard
Detroit, MI 48202.

Patient Name: (required)	**Physician Name:**
Patient Member ID: (required):	**Physician Specialty:**
Drug Name/Strength/Quantity (Capital Letters):	**Physician Phone Number:**
Amount Paid:	**Pharmacy Phone Number:**
Attach Pharmacy Receipt (Legible Copy/Original) Note: A copy of your pharmacy receipt can be obtained from your pharmacy. A claim cannot be processed without a receipt	**Reason for Reimbursement Request**

If the requested information is not received your prescription drug claim cannot be processed for payment. If you have any questions or concerns, please contact Client Services at (313) 664-7015 or toll-free 1-800-801-1770, Monday through Friday 7 a.m. to 7 p.m. and Saturday 8 a.m. to noon. Members with hearing or speech impairments may call TDD (313) 664-8000.