Foreign Claims Reimbursement Form

Please use this form each time you submit claims to us for review and payment. Complete one form per family member. Keep a copy of all receipts and documents for your records. Please allow 30 days for processing. Any missing information will cause a delay in processing your claim.

Step 1: Member information (please print)

Patient name: _____ ID number: _____

Address: _____ Date of birth: _____

City, State, ZIP: _____

Contact number: _____

Step 2: Submission information

a. Attach the itemized bill or statement that includes:

- Patient's name
- Date of service
- Please provide in detail the reason for treatment:

_____

_____

- Dollar amount charged for each service
- Provider's name and address

b. Attach the proof of payment. Please tape any receipts to a separate sheet of paper with this form. Remember to make copies of all receipts and documents to keep for your records.

c. Services were provided at:

- ❑ Hospital inpatient
- ❑ Hospital emergency room
- ❑ Urgent care center
- ❑ Cruise ship
- ❑ Hotel doctor
- ❑ Doctor's office
- ❑ Pharmacy
- ❑ Other: _____

d. Provide translated versions for all the above information.

Step 3: Send to

HAP Claims Division
Member Reimbursement
2850 W. Grand Blvd.
Detroit, MI 48202

If you have any questions or concerns, please call the Customer Service number on your ID card.