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)**

<table>
<thead>
<tr>
<th>Patient name:</th>
<th>ID number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Date of birth:</td>
</tr>
<tr>
<td>City, State, ZIP:</td>
<td>Contact number:</td>
</tr>
</tbody>
</table>

**Step 2: Submission information**

1. Attach the itemized bill or statement that includes:
   - Patient’s name
   - Date of service
   - Dollar amount charged for each service
   - Provider’s name and address
   - Please provide in detail the reason for treatment:

2. 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.

3. Services were provided at:
   - Hospital inpatient
   - Hotel doctor
   - Hospital emergency room
   - Doctor’s office
   - Urgent care center
   - Pharmacy
   - Cruise ship
   - Other: ____________________________

4. 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.

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