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 60 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: ____

City, State, ZIP: ____

Date of birth: ____

Contact number: ____

Step 2: Submission information:

a. 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
____

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. Request must be received within one year from the date of service in order to be considered for processing.

d. Services were provided at:
- Hospital Inpatient
- Hospital Emergency Room
- Urgent Care Center
- Cruise Ship
- Hotel Doctor
- Doctor's Office
- Pharmacy
- Other

e. Provide translated versions for all above information.

Step 3: Sign:

____

Required: Your Signature or legally authorized personal representative. Personal representative must include the appropriate legal documentation.

Step 4: Send to:

HAP Claims Division
Member Reimbursement
2850 West Grand Boulevard
Detroit, MI 48202

If you have questions, call our Customer Service team at the number on your ID card. Or dial 711 for TTY service.