Direct Member and Enrollee 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
- Procedure and diagnosis codes
- Provider's name, address, and Phone number
- Provider's tax identification number and NPI

b. Attach the proof of payment. i.e. Credit Card Receipt, Banking Statement, or Canceled Check

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

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.