



## 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 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: \_\_\_\_\_

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 for example, credit card/digital payment 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.

HAP and its subsidiaries do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

© 2022 HAP—a nonprofit company

HAP32552 – 9/2022

2850 West Grand Boulevard, Detroit, Michigan, 48202 | hap.org