UNIVERSITY OF MICHIGAN HEALTH PLAN
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Statement of Medical Claims Form

SECTION A: INSTRUCTIONS

To request a refund, please complete this form in its entirety. For your request to be reviewed, you must also include an itemized receipt from the provider that includes: the date of service, the total billed amount for each service, procedure code for each service, diagnosis code, and proof of payment. Please keep your original documents. For claims with the United States, please allow 4-6 weeks for processing.

SECTION B: TO BE COMPLETED BY INSURED

Insured Member's Name:			Member ID number:
Address:			
City:	State:	Zip:	Marital status:
Daytime phone number:		Evening phone number:	
Employer:			
Spouse's name:		Name and address of spouse's employer (if employed):	

SECTION C: PATIENT INFORMATION

Patient's name:		Patient's date of birth:	Patient's phone number:
Subscriber member ID (found on ID card):			Patient's relationship to employee:
Provider name:			Date of service:
Was this due to an auto accident? ☐ Yes ☐ No	Was this due to a dental injury? ☐ Yes ☐ No		Was this an emergency? ☐ Yes ☐ No
If injury, was it job related? ☐ Yes ☐ No	Please explain:		
Provider name	*Provider tax ID:		*Procedure code:
*Diagnosis code:		*NDC if reimbursement is for a drug:	
Do you or any members of your immediate family have any other group insurance that may cover all or part of this claim? ☐ Yes ☐ No		If yes, give the insurance company name, address, and group number.	

**You can obtain this information from the provider. This information is required to process your claim. Processing may be delayed if this information is not provided.*

SECTION D: AUTHORIZATION

I certify the above statements are true and correct to the best of my knowledge and hereby authorize any physician, hospital, employer, union, insurance company, HMO, or prepayment organization to supply each other any information required in connection with this claim. A photocopy of this authorization shall be valid as the original.

Insured's signature Date

SECTION E: FRAUD WARNING

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

Please return to:

University of Michigan Health Plan
PO Box 30377
Lansing, MI 48909-7877
Fax: 517-364-8411

If you have questions, please contact Customer Service at 800-832-9186 Monday through Friday from 8:30 a.m. to 5:30 p.m. ET.