



P.O. Box 68767  
Grand Rapids, MI 49516-8767

# Member Reimbursement Form

Customer Service

Phones  
1-800-662-6667  
1-800-257-9980 (TTY users)

Hours  
8 a.m. to 5:30 p.m.  
Monday through Friday

I paid out of pocket and am requesting reimbursement for medical services.

*Please attach receipts from medical providers along with copies of your cancelled check (front and back) or credit card receipt.*

## MEMBER INFORMATION

Patient Name		Date of Birth	
Subscriber Name		Contract No.	
Address		City	State Zip Code
Phone Day – Evening –	PCP who wrote referral		PCP Number (if known)

## PROVIDER / BILLING INFORMATION

Provider Name		Provider Name	
Address		Address	
Phone		Phone	
Services		Services	
Date of Service ▶		Date of Service ▶	
Total Charges ▶ \$	If Requesting Reimbursement, Total Paid ▶ \$	Total Charges ▶ \$	If Requesting Reimbursement, Total Paid ▶ \$

*NOTE: If you are reporting more than two services, add a separate sheet for each item and supply the necessary documentation.*

## ADDITIONAL INFORMATION: Complete any information that applies.

1. Was the above service rendered on an emergency basis?  Yes  No
2. Was your BCN primary care physician notified?  Yes  No – If No, explain below
3. Were you referred to the attending provider by your primary care physician?  Yes  No – If No, explain below

If applicable, please explain why services were not performed by a BCN participating provider.


Please explain the circumstances regarding your claim/reimbursement request.  
(Attach additional sheets if necessary.)


## I CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT.

Subscriber's Signature	Date
------------------------	------