

# Member Deductible Credit Request



SECTION 1 - MEMBER INFORMATION		
Member Name	Contract Number (with suffix)	Group Number
Address		City, State Zip Code
SECTION 2 - INSTRUCTIONS		
Please attach your Explanation of Benefits to the <b>Upper Left-Hand Corner</b> of this document. (Please do not staple)		
SECTION 3 - EXPLANATION OF BENEFITS		
<b>Explanation of Benefits must contain the following:</b>		
* Patient Name		
* Date of Service		
*Amount applied to deductible for each date of service.		
SECTION 4 - MEMBER COMMENTS		
SECTION 5 - SIGNATURE		
The above statements and attachments are true and complete to the best of my knowledge.		
Signature: _____		Date: _____
MAIL TO: McLaren Health Plan ATTN: Claims Dept. P.O. Box 1511 Flint, MI 48501-1511		
QUESTIONS? Call Customer Service at (888) 327-0671		