McLaren HEALTH ADVANTAGE

McLaren HEALTH PLAN COMMUNITY

Direct Member Reimbursement Form

Please fill out this form completely. Services will be reimbursed at the benefit level and at McLaren's Reimbursement Amount. You may not receive reimbursement for the full amount you pay out-of-pocket.

If services require authorization, they must be authorized prior to requesting reimbursement or your request will be denied.

Note: You should not be paying a contracted McLaren provider out-of-pocket for services, except for your applicable co-pays, coinsurance, or deductible.

Proof of payment MUST be included with this form for consideration.

Patient Name:________________________________Member ID: ______________________________

Subscriber Name:_____________________________Phone Number: ___________________________

Address: ____
(Street) (City) (State) (Zip)

Medical Services (Office visits, Physical Therapy, Chiropractor, DME etc.)

Provider Name:______________________________Provider Tax ID: _____________________

Date of Service:_____________________________Amount Paid: _______________________

Diagnosis:__________________________________Procedure Codes: ____________________

Note: Attach all documentation provided by the office showing services, diagnosis, and charges.

Pharmacy Services (Prescriptions)

Pharmacy Name: ____

Date Prescription Filled: ____

Medications: ___________________________ ______________________________________

___________________________ ______________________________________

Signature:____Date: ______________________

Please mail, fax or email completed form along with proof of payment to:

McLaren Health Plan Community/McLaren Health Advantage
Attention: Customer Service Manager
G-3245 Beecher Road
Flint, MI 48532
Fax #: 833-540-8648
Email: CustomerService@McLaren.org

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REIMBURSEMENT REQUEST FOR AT-HOME COVID-19 TESTING

Please complete the following information for COVID-19 tests that you paid for out of pocket.

COMPLETE ONE REQUEST PER PERSON

***Important Information**

- Only FDA authorized tests are eligible for reimbursement
- Tests purchased before January 15, 2022 will not be covered unless ordered by your health care provider
- Proof of payment MUST be included with this form. Include the following:
  - An original paid receipt that includes the name of the test
  - UPC code from the package
  - Date of purchase
- Limit of 8 per member per month
- Tests for employment purposes are not eligible for reimbursement

Complete the Following Information About the Member:

Patient Name:___________________________________Member ID: _________________________________

Subscriber Name:________________________________Phone Number: ______________________________

Address: ____

Complete the Following Information About the At-Home COVID Test:

Name of the FDA Authorized Test and Manufacturer:____

UPC Code:____

Place of Purchase (e.g., name of pharmacy):____

Number of Tests Purchased:____

If Multiple Tests, Number of Tests Per Box:____

Reimbursement Amount Requested:____

By signing and submitting this form, I attest that this information is accurate and complete. I also am stating that the tests are not used for employment purposes. Knowingly filing false, incomplete or misleading information may be subject to criminal or civil penalties.

Signature:____Date:___________________________

Please mail, fax or email completed form along with proof of payment to:

McLaren Health Plan Community/McLaren Health Advantage

Attention: Customer Service Manager

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