



# Member Reimbursement Form

Customer Service Phones  
800-662-6667  
TTY users  
800-257-9980

*Please check all that apply.*  
I paid out of pocket and am requesting  
reimbursement for:

- Pharmacy prescription
- Medical service

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

P.O. Box 68767  
Grand Rapids, MI 49502-1658

Customer Service Hours  
8:30 a.m. to 5 p.m.  
Monday through Thursday  
9:30 a.m. to 5 p.m. Friday

## 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.

- Was the above service rendered on an emergency basis?  Yes  No
- Was your BCN primary care physician notified?  Yes  No – If No, explain below
- 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
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