Mail Form To: CoreSource
PO Box 2310
Mt. Clemens, MI 48046

PLEASE DO NOT STAPLE IN THIS AREA

HOSPITAL BASED/PHYSICIAN DIRECTED PROGRAM REIMBURSEMENT FORM

1. Participant's first name:______________________________ Participant's last name: ______________________________	2. Participant date of birth: Month / Day / Year 3. Relation to Member: Self / Spouse / Child / Other	4. Member ID #: ________________
5. Member's first name: ________________________________ Member's last name: ________________________________	6.Member's Address: ____ ____	

NOTE: Reimbursement is based on attendance and payment of program costs.
Reimbursement will not be greater than 50% of amount paid-to-date by member.

Program Cost:

- ✓ Copy of Itemized Payment Receipt (only program costs are eligible for reimbursement, not supplements, etc.)
- ✓ Below attendance Record – to be completed at the class by a PROGRAM facilitator

Reimbursement is based on a minimum of 6 sessions attended or at program end if less than 6 remaining.
Reimbursement checks will be made out to the member and mailed to his/her home address.

Program Name: ____

Program Location: ____

Program Facilitator (Name): ____

Program Facilitator (Phone) : ______ - ________ - ________

Duration of Program:_____________Program BEGIN Date:___/____/______

Date	Program Facilitator verifying attendance (please print and sign name)
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OSU Health Plan, Inc. reserves the right to verify attendance and payment of services in the program before reimbursement of benefit.

Any person who, with intent to defraud or knowing that he 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.

NGS USE ONLY: 278 99404

HOSPITAL BASED/PHYSICIAN DIRECTED PROGRAM REIMBURSEMENT FORM

Complete only if requesting reimbursement for more than 6 weeks of Hospital Based/Physician Directed program. MUST be attached to Page 1.

1. Participant's first name:_______________ Participant's last name: _______________	2. Participant date of birth: Month Day Year [ ] [ ] [ ] 3. Relation to Member: Self Spouse Child Other [ ] [ ] [ ] [ ]	4. Member ID #: _______________
5. Member's first name: _______________ Member's last name: _______________	6.Member's Address: _______________ _______________	

Program Cost: _______________

Date	Program Facilitator verifying attendance (please print and sign name)
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