MESSA
Good health. Good business. Great schools.

Save Form | Reset Form | Print Form

1475 Kendale Blvd., P.O. Box 2560
East Lansing, Michigan 48826-2560
517.332.2581 • 800.292.4910
Fax: 517-333-6229
www.messa.org

Claims Reimbursement Form

Please complete this entire form and attach/include as much information as possible.

MESSA Member / Patient Information *(Please Print)*

First Name of Member	Last Name of Member		Enrollee ID Number
First Name of Patient	Last Name of Patient		Patient's Date of Birth (MM/DD/YY)
Address			Home Phone # ( )
Address 2			School District
City	State	Zip Code	Work / School Phone # ( )

Claim Information

Type of Service: (i.e., lab, office visit, supply, x-ray)	Procedure Code:
Individual Charge Detail for Each Type of Service:	
Diagnosis:	Diagnosis Code Number:

Important Note: *Your bill/receipt must accompany this form for processing.*
Please remember to attach your itemized bill/receipt for reimbursement consideration.

Provider Information

Name of Provider or Facility			Degree
Address			Tax ID Number
Address 2			National Provider Identification (NPI) Number
City	State	Zip Code	Telephone Number ( )

Reimbursement Instructions

Send payment to: ☐ Member ☐ Provider