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MESSA Claims Reimbursement Form

1475 Kendale Blvd., P.O. Box 2560, East Lansing, MI 48826-2560
800-292-4910 | TTY: 888-445-5614 | Fax: 517-333-6229 | **messa.org**

Please complete this entire form. Claims received missing any of the pertinent information listed below will cause a delay in processing.

Important Note: Attach your itemized bill/receipt, which should include the following important information from your provider:

- Patient name
- Date of service
- Procedure code
- Diagnosis code
- Individual rendering provider's name

1 Member/Patient Information *(please print)*

MEMBER FIRST NAME | **MEMBER LAST NAME** | **SUBSCRIBER ID**

PATIENT FIRST NAME | **PATIENT LAST NAME** | **PATIENT DATE OF BIRTH** (MM/DD/YYYY)

ADDRESS | **ADDRESS 2**

CITY | **STATE** | **ZIP CODE** | **PHONE NUMBER** (HOME/CELL)

2 Provider Information *(please print)*

PROVIDER OR FACILITY NAME | **CREDENTIALS**

ADDRESS | **ADDRESS 2**

CITY | **STATE** | **ZIP CODE** | **PHONE NUMBER** (PROVIDER)

TAX ID NUMBER | **NATIONAL PROVIDER IDENTIFICATION (NPI) NUMBER**

3 Reimbursement Instructions

SEND PAYMENT TO:

☐ **MEMBER** ☐ **PROVIDER**

4 Submit your Forms

- Mail
- Fax
- MESSA app
- Secure message through your MyMESSA member account *secure.messa.org/MemberPortal*