McLaren Health Plan
PO Box 1511
FLINT, MI 48501-1511

Return Service Requested

McLaren HEALTH PLAN

Questions Call us at 888-327-0671

Member name and address information

Group No.:
Division:
Check #:
Check Date:

Date you had services

Description of services provided

Any member responsibility

Explanation of Benefits - This is not a bill

No.	Date(s) Of Service	Proc Code	Description Of Service	Total Charges	Provider Discount	Ineligible Amount	Ineligible Code	Deductible	Co-Pay/ Co-Ins	Other Carrier	Benefits Paid
Claim#:				Insured Name:					Insured ID		
Patient Acct#:				Patient Name:							
01											
02											
Provider			Claim Sub-Totals:								

Total billed by your provider

Total amount McLaren paid your provider

Claim Number Comment

*** Upon request, we will provide you with applicable diagnosis and treatment codes and their meanings. To request this information, contact Service at (888) 327-0671.

Payment To: Check Date Check No. Amount Accumulator Information

Provider/Office Name

Current amounts remaining for your cost-sharing benefits for the Individual or Family

IND OPTION B DEDUCTIBLE REMAI
FAM OPTION B DEDUCTIBLE REMAI
IND OPTION A DEDUCTIBLE REMAI
FAM OPTION A DEDUCTIBLE REMAI
INDIVIDUAL COINSURANCE REMAI
FAMILY COINSURANCE REMAINING
IND IN-NET OOP REMAINING
FAM IN-NET OOP REMAINING
IND OUT-NET OOP REMAINING
FAM OUT-NET OOP REMAINING

Patient Responsibility

Provider	Deductible	Coinsurance	Copayment	Non-Covered	Total