PRESCRIPTION REIMBURSEMENT FORM

Claim Number: _____ Claimant: _____

Date	Name & Address of Providing Physician	Amount of Attached Receipt
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Please note, if any of the boxes below are not acknowledged, the document will be considered incomplete and will be returned for further completion. The claim cannot be considered until all acknowledgments are checked.

☐ I have reviewed this document and attest that the information contained therein is true and accurate.

☐ I acknowledge I have read the following fraud warning:

A person who presents or causes to be presented an oral or written statement, including computer-generated information, as part of or in support of a claim to the Michigan Property & Casualty Guaranty Association ("MPCGA") for payment or any other benefit knowing and with an intent to injure, defraud, or deceive the MPCGA that the statement contains false information concerning a fact or thing material to the claim commits a fraudulent insurance act under the insurance code that is subject to the penalties imposed by law. A claim that contains or is supported by a fraudulent insurance act as described in this subsection is ineligible for payment or benefits by the MPCGA.

By signing below I certify the above services were incurred / provided

Guardian/Claimant Signature: _____ Date: _____