Provider Refund Remittance Form

TIN	NPI	Provider Name	Check Number

Member Name	Member ID Number	Member Date of Birth	Claim Number	Date of Service	Refund Amount	Full or Partial Refund	If Partial Refund CPT Code(s)	Reason for Refund

Mail the check and this form to:

**Only one TIN/NPI per form and check*

McLaren Health Plan
Attn: Finance Department
G-3245 Beecher Rd
Flint, MI 48532

McLaren HEALTH PLAN