Complete one form for each beneficiary for each month of service.

Revised October 2021

Adult Foster Care (AFC) or Home for the Aged (HFA) Organization Name:			**PERSONAL CARE SUPPLEMENT** **REQUEST FOR REIMBURSEMENT**
Mailing Address:			
City:	State:	Zip Code:	UPHP UPPER PENINSULA HEALTH PLAN MI HEALTH LINK Linking Medicare and Medicaid for you
Phone:	National Provider Identification or Tax ID Number:		
AFC/HFA home owner? ☐ Person ☐ Organization			

Beneficiary's First and Last Name	Beneficiary's Medicaid ID #	Beneficiary's DOB	Beneficiary's Gender	Beneficiary's Address	Dates of Service	Amount Charged: **Note:** The curernt rate for a full month is $250.92
					_____/_____/_____ **To** _____/_____/_____	

REMARKS

CERTIFICATION: By signing this claim, you are attesting that you and/or your organization rendered personal care services to the above beneficiary in the specified time frame, and you believe the beneficiary to be eligible for the personal care supplement.

Provider Signature:

Title:

Date:

Send Completed Form To:

Mail:
Upper Peninsula Health Plan
Attn: Claims
853 W.Washington St
Marquette, MI 49855

Fax:
(906) 225-8770

Email:
ClaimServices@uphp.com

If you have questions about this form, please call Claims Services at (906)225-7746.