Claim Form for MRP & ACP

Name of Employer:_____

Employee Name: _____ Employee Phone Number: _____

Patient Name: _____ Number of Attached Pages: _____

Member Social Security #: _____ Today's Date: _____

Seeking Reimbursement for: (check all that apply)

- ☐ Medical Reimbursement Plan (MRP) – *I have deductibles, coinsurance and/or copayments from my other insurance.*
- ☐ ACP – *I have deductibles, coinsurance and/or copayments from my other insurance*.

-Attach a copy of your Explanation of Benefits or your pharmacy receipts.
-Retain a copy of your EOB, pharmacy receipts and this form for your records.
-When submitting pharmacy receipts, Please DO NOT send the cash register receipt. Please send the pharmacy receipt that shows the patient's name and address, the pharmacy name and address, the date the prescription was filled, the name of the prescription drug and the amount of the co-pay or amount paid.

To submit reimbursement claim forms: Submit through the www.MutualMedical.com Member Portal, email to ACP.MRP@MutualMedical.com, Fax to 309-674-5420, or mail to Mutual Medical, PO Box 689, Peoria, IL 61652

Date of Service	Name of Provide Group/Pharmacy/Address incl City/State/Zip	Provider Phone #