HRA FAX TRANSMITTAL

TO FAX # 517-763-0200

DATE: _________________

FROM: ____________________________________________________________

(NAME)         (FAX #)

CONTACT PHONE NUMBER: _____________________________________________

MESSAGE:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

BEFORE YOU FAX: It is REQUIRED that the beneficiary Name and Member ID are on all pages of the HRA, and the beneficiary is currently enrolled in a Medicaid Health Plan.

TOTAL NUMBER OF PAGES INCLUDING COVER SHEET __________

**CONTACT INFORMATION AND TOTAL NUMBER OF PAGES ARE REQUIRED**

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