healthfirst
Health Insurance for New Yorkers

Healthfirst EPO Plan Member Reimbursement Form

Please complete this form and submit it with the supporting documentation (receipts and bills) to request reimbursement for the eligible service that was paid for out of pocket. You may submit only one reimbursement request at a time. If you believe there was a deductible or coinsurance/copayment overpayment, please contact the provider directly. ***This form cannot be used to request reimbursement for out-of-pocket payments for non-eligible services.***

The following are instructions for completing each section. Please read carefully before filling out this form.

Section 1 Member Information

- Write your Member ID #, found on your Healthfirst ID card
- Write your name as shown on your ID card (First Name, Last Name)
- Write your complete mailing address
- Write your telephone number in case we need to reach you to verify any information

Section 2 Reimbursement Information

- Write the amount to be reimbursed

Section 3 Reason for Reimbursement Request

- Please note that you may be reimbursed only for emergency room services. Plus, you may submit only one reimbursement request at a time.

Section 4 Attached Supporting Documentation

- Check the type of supporting documentation (receipt and bill) you will attach with your form

Section 5 Member Attestation and Signature

- Review, sign, and date your form to certify that the information on the form and any document(s) attached are accurate and complete
- If you are not the member and are signing this form, please provide us with your contact information in the space provided
- Please attach and mail any supporting documentation with the completed form to:

Healthfirst Insurance Plan
P.O. Box 1566
New York, NY 10274-1566

- To email form please send to: **commercialmemberservice@healthfirst.org**
  Or Fax: **1-646-313-9059**

If you have any questions or need additional help with filling out this form, please call our Member Services department at **1-855-789-3668** (TTY 1-855-779-1033), Monday to Friday, 8am–6pm.

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Member Reimbursement Form

Section 1 Member Information

Member ID # _____

First Name _____ Last Name _____

Address _____

City _____ State _____ Zip _____

Telephone (including area code) (_____) _____

Section 2 Reimbursement Information

Amount of reimbursement requested: **$** _____ . _____

Section 3 Reason for Reimbursement Request

Emergency room services

Section 4 Attached Supporting Documentation

Check all that apply

- ☐ Receipt – Proof of payment
- ☐ Provider claim form listing diagnosis and procedure codes

Section 5 Member Attestation

By signing below, I certify that I have paid the dollar amount listed for the specified services received while a Healthfirst EPO Plan member. I further certify that the documents attached to this form demonstrating proof of payment are accurate, true, and complete, in all respects. I also understand that any Healthfirst determination for reimbursement will be made subject to cost share and coinsurance requirements.

Signature _____ Date _____

*If you are the authorized representative, you must sign above and provide the following information:

Name _____ Phone # (_____) _____ Relationship to Enrollee _____

Address _____