healthfirst

Healthfirst, Inc.
P.O. Box 5165
New York, NY 10274-5165

Member Transportation Reimbursement Claim Form

Member Services department:1-866-463-6743, Monday through Friday, 8am–6pm
Fax number: 1-212-801-3250

Please complete this form in full. Have your Healthfirst provider sign at the bottom and return it to the address listed above to receive reimbursement. Use one form for each appointment or service. Attach receipts for verification. This form is only valid for Long Island members.

Member/Patient Name	Healthfirst ID #
Date of Birth	Telephone ( )

REIMBURSEMENT IS FOR COST INCURRED ON (mm/dd/yyyy) _____ **(DAY OF APPOINTMENT)**

NAME OF HEALTHFIRST PROVIDER SEEN: _____

Check here if you used: ❒ **BUS**

Number/Route: _____
From: _____
To: _____
Cost Per Person
- ❒ One Way $_____
- ❒ Transfer Needed + $_____
- ❒ Return Trip + $_____
- ❒ Transfer Needed + $_____

Total Cost Per Person = $_____
Number of People on Trip x _____
Total Cost for Trip = $_____

Check here if you used: ❒ **TRAIN**

Line/Route: _____
From: _____
To: _____

Cost Per Person
Total Cost Per Person = $_____
Number of People on Trip x _____
Total Cost for Trip = $_____

Check here if you used: ❒ **PRIVATE CAR**

License/Plate Number: _____
From: _____
To: _____

Number of Miles Driven _____
11 Cents Per Mile x .11 $_____
Total Cost for Trip $_____

Please provide additional information about the money you have spent. Please remember to provide your receipt(s) in order to be reimbursed.

By signing below, I hereby certify that the information I have provided is true and the expenses claimed are for transportation to covered Healthfirst medical services.

Head of Household or Member (Signature): _____ **Date:** _____

THIS CLAIM WILL NOT BE PROCESSED UNLESS PROPERLY FILLED OUT BY THE PROVIDER'S OFFICE

HEALTHFIRST PARTICIPATING PROVIDER USE ONLY: I verify that the above Healthfirst member was seen in my office on this day for covered medical services.

Provider Name (print): _____ Address/Facility/Clinic: _____

Provider Signature/Office Stamp: _____ *Required for payment.