healthfirst®
Health Insurance for New Yorkers

Flex Reimbursement Claim Form

The Flex Reimbursement Claim Form is only used to request reimbursement for Signature (PPO) dental, vision, and hearing out-of-pocket costs.
Vision: Eyewear purchased through a network provider (above the allowance of $250 per two years included in your plan)
Dental: Copays for out-of-network services and/or costs for services above and beyond your $1,500 annual allowance
Hearing: Copays for hearing aids purchased through NationsHearing
It's important to first show your provider your Healthfirst Member ID card to use all of your regular dental, vision, and hearing benefits; then use your Flex card for any out-of pocket costs! The Flex card is for individual use only, not for use by family members or friends. It cannot be converted to cash, and cash reimbursements will be deducted from your Flex card balance. In the event the balance is less than the amount submitted, you will be reimbursed only up to the amount of your card balance at the time your request is received.

Below are the instructions for completing each section. Please read carefully before completing this form.

Section 1 | Member's Information

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

Section 2 | Expenses and Form Submission Information

- Using your receipts, fill in the date of purchase (mm/dd/yyyy), location of purchase, item(s)/service(s) purchased, and the amount paid for each item/service. *If you need more space to list your purchases, be sure to fill out and attach an additional form.*
- Write the grand total for all the item(s)/service(s) you're requesting for reimbursement.
- Attach the original itemized receipts from your eligible out-of-pocket vision, dental, or hearing purchases. **Do not send canceled checks, credit card statements, or bank statements.**
- Review, sign, and date the completed Flex Reimbursement Claim Form and submit it to Healthfirst in any of the following ways:
  - Email: OTCINQUIRIES@Healthfirst.org
  - Fax: 212-801-3250
  - Mail: Healthfirst OTC Inquiries
P.O. Box 5175
New York, NY 10274-5175

If you have any questions or need assistance with completing this form, please call your dedicated Member Services team at 1-833-350-2910, 7 days a week, 8am–8pm (October through March), and Monday to Friday, 8am–8pm (April through September). If you require in-person assistance with filling out this form, visit any Healthfirst Community Office.

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Section 1 | Member's Information

Member's Name	Member's Address
Healthfirst Member ID Number	Member's Date of Birth (DOB)
Flex Card Number	Member's Phone Number

Section 2 | Flex Card Expenses

This section MUST be completed in full. Requests submitted with incomplete information cannot be processed and will be returned. Please complete all the fields listed below to ensure that your claim is processed timely. Supporting documentation is required for all expenses.

Purchase Date (mm/dd/yyyy)	**Location of Purchase**	**Items/Services Purchased**	**Expense Amount**
			$
			$
			$
			$
			$
			$

Grand Total $ ___________________________

I understand that the purchases are for my use only and cannot be purchased for friends or family members.

_______________________________________ _______________________________

Member's Signature Date

Was this form easy to fill out? Yes No

If No, please explain why ____

Coverage is provided by Healthfirst Health Plan, Inc. or Healthfirst Insurance Company, Inc. ("Healthfirst"). Healthfirst Medicare Plan has HMO and PPO plans with a Medicare contract. Our SNPs also have contracts with the NY State Medicaid program. Plans contain exclusions and limitations.

Healthfirst complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al 1-866-305-0408 (TTY 1-888-867-4132).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-305-0408
(TTY 1-888-542-3821)。

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