healthfirst
Health Insurance for New Yorkers

Healthfirst Medicare Plan Member Reimbursement Form Instructions

The Healthfirst Medicare Plan Member Reimbursement Form lets you request reimbursement for eligible care and services that you paid for out of pocket. To ensure timely processing, please fill out all requested informationand attach supporting documentation. **Incomplete requests will be returned.** Reimbursement requests for non-eligible care or services will be denied. Please submit only one reimbursement request at a time.

If you have any questions or need additional help with this form, please call Healthfirst Member Services at **1-888-260-1010** (TTY 1-888-542-3821), 7 days a week, 8am–8pm. If you need in-person assistance with this form, please visit one of our convenient Healthfirst Community Offices. Hours and locations are available on our website at **Healthfirst.org/healthfirst-community-office**. Here are some tips on how to complete this form:

Section 1 | Reimbursement Reason

- Select the reason for your reimbursement request
- If you do not see your reason listed, please provide a detailed description in the box listed as “Other”

Section 2 | Member Information

- Write your Member ID number, which can be found on your Member ID card
- Write your name as shown on your Member ID card
- Write your telephone number in case we need to reach you to verify any information

Section 3 | Member Attestation

- Sign and date your form to certify the information on the form and in the documents attached is accurate and complete
- If you are acting as a Beneficiary Representative, be sure to complete and attach the Appointment of Representative form, available at **https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**
- Attach the supporting documentation and submit the completed form to:

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

Section 4 | Reimbursement Details

- Please provide the details of the care or service you received, including the date, a description, the provider’s contact information, and the amount you paid
- Include multiple entries related to the same care or service, as needed

Section 5 | Supporting Documentation

- Please make sure your supporting documentation is clear and legible
- Include your Member ID at the top of each page of any supporting documents
- **Do not submit original receipts**. Keep original documents in a safe place and submit copies to Healthfirst

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Healthfirst Medicare Plan Member Reimbursement Form

Section 1 | Reimbursement Reason

- ☐ I did not use my Member ID Card
- ☐ I went to an out-of-network provider (please explain) ______________________
- ☐ I was traveling out of the country
- ☐ Other (please explain) ______________________
- ☐ I'm requesting a transportation reimbursement

Section 2 | Member Information

Member ID number (located on your Healthfirst Member ID card)			
Name	Phone Number		
Address	City	State	Zip Code

Please check if you are the: ☐ Member OR ☐ Beneficiary Representative

If you are the Beneficiary Representative, please attach the required Appointment of Representation (AOR),Power of Attorney, or Executor of Estate form. The AOR form can be found at **https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.**

Section 3 | Member Attestation

By signing below, I attest that I have paid the dollar amount listed below for the services received while a Healthfirst Medicare Plan member. I further certify that the documents attached to this form demonstrating proof of payment are accurate, true, and complete in all respects.

______________________ ______________

Signature (Required) **Date**

______________________ ______________

Beneficiary Representative Signature **Date**

If you are signing as a Beneficiary Representative, we require both your signature and the member's signature.

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Section 4 | Reimbursement Details

Provide the details of your reimbursement request below. Include multiple entries related to the same care or service, as needed.

Date of Care or Service	Description of Care or Service
Provider's Name	Provider's Address
Provider's Phone Number	Amount Paid: $

Date of Care or Service	Description of Care or Service
Provider's Name	Provider's Address
Provider's Phone Number	Amount Paid: $

Date of Care or Service	Description of Care or Service
Provider's Name	Provider's Address
Provider's Phone Number	Amount Paid: $

Section 5 | Supporting Documentation

Supporting documentation showing proof of payment is required. If you do not have a detailed receipt for each service, please request a copy from the provider. Reimbursement requests missing proof of payment information may be denied/dismissed. Please make sure your copies are clear and legible. **Do not submit original receipts. Submit all supporting documentation to**:

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

Healthfirst Health Plan, Inc., offers HMO plans that contract with the Federal Government. Healthfirst Medicare Plan has a contract with New York State Medicaid for Healthfirst CompleteCare (HMO SNP) and a Coordination of Benefits Agreement with the New YorkState Department of Health for the Healthfirst Life Improvement Plan (HMO SNP). Enrollment in Healthfirst Medicare Plan depends on contract renewal. Healthfirst Medicare Plan 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 1-888-867-4132)。

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