healthfirst®
Health Insurance for New Yorkers

Over-the-Counter (OTC) Reimbursement Claim Form

The OTC Reimbursement Claim Form is supplied to request reimbursement for ***eligible*** OTC item(s) that you purchased out of pocket. OTC items may be purchased for your individual use only, not to be used by family members or friends. The Healthfirst OTC card is not a debit or credit card and cannot be converted to cash, nor can it be used to purchase Part B or Part D covered prescription drugs. Cash reimbursement will be deducted from your OTC 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. ***This form cannot be used to reimburse for non-eligible OTC items, prescription cost, or any medical services you received.***

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

Section A Member's Information

- Write your name (First Name, Last Name) as shown on your Healthfirst ID card.
- Write your member ID number found on your Healthfirst Member ID Card.
- Write your 19-digit OTC Card number found on your OTC card.
- Write your complete mailing address.
- Write your telephone number in case we need to reach you to verify any information you provided.

Section B OTC Expenses, Member's Signature, and Mailing Information

- Using your receipts, fill in the date of purchase (mm/dd/yyyy), location of purchase, item(s) purchased, and the amount paid for each item. *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) being claimed.
- Attach the original itemized receipts from your pharmacy/store where the eligible items were purchased. **Do not send cancelled checks, credit card, or bank statements.**
- Review, sign, and date the completed OTC Reimbursement Claim Form and mail to:

Healthfirst Product Management
P.O. Box 5175
New York, NY 10274-5175

You can find a list of OTC eligible items in your OTC pamphlet included in your member welcome kit packet, or you can obtain a copy from our website at Healthfirst.org/Medicare.

If you have any questions or need assistance with completing this form, please call:

Member Services
1-888-260-1010 (TTY: 1-888-542-3821), 7 days a week, 8am to 8pm

If you require in-person assistance with filling out this form, you may visit one of the nearest Healthfirst Help Centers.

H3359_MSD17_45 Accepted 02282017

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SECTION A: Member's Information

Member's Name:	Member's Address:
Member's ID Number:	Member's DOB:
OTC Card Number:	Member's Phone Number: ( )

SECTION B: OTC Expenses

This section MUST be completed in full. Requests submitted with incomplete information cannot be processed and will be returned. Please complete all of 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	Item Purchased	Expense Amount
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$

Grand Total: $ _____

I understand that I can only be reimbursed for CMS-approved, eligible OTC and health-related items. I understand that items purchased are for my use only and cannot be purchased for friends or family members. If I am seeking reimbursement for a dual-purpose item, I attest that prior to purchasing the dual-purpose item(s) included here, I had a discussion with my provider, who verbally recommended the item(s).

_____ _____

Member's Signature Date

Was this form easy to fill out? ☐ Yes ☐ No

If No, please explain why _____

For Office Use Only

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 York State Department of Health for the Healthfirst Life Improvement Plan (HMO SNP). Enrollment in Healthfirst Medicare Plan depends on contract renewal.

Healthfirst Medicare Plan, Inc. 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)。