



**MEMBER REIMBURSEMENT FORM**

MetroPlus Member Information	
Name (Patient/Member):	Member ID:
Street Address:	Medicare Number:
City, State, Zip Code:	Telephone Number: (    )

Expense Information	
Date of Service (MM/DD/YYYY):	_____
Type of Service:	<input type="checkbox"/> Transportation <input type="checkbox"/> Emergency Care <input type="checkbox"/> Out-of-Network Care <input type="checkbox"/> Other (please describe below) _____ _____
Provider Address:	_____
Provider Telephone Number:	(    )
<b>Total Amount:</b>	\$ _____

By signing this form, I certify that my statements on this form are complete and true. I understand that my request can be denied if I do not provide the required documentation to support my request.

**Sign Here ►**

**Date:** \_\_\_\_\_

**Helpful Tips to Ensure Speedy Processing:**

- ✓ Fill out the form completely
- ✓ Please Print
- ✓ Attach the necessary documentation to support your request
- ✓ Attach a proof of payment
- ✓ Make a copy of this form and supporting documentation and retain it for your records
- ✓ Staple documents together and mail to:

Attention: Customer Services  
 MetroPlus Medicare Advantage Plans  
 160 Water Street, 3<sup>rd</sup> Floor  
 New York, NY 10038

If you have questions about this form or need help filling it out, please call Customer Services at-1-866-986-0356 or for the hearing impaired TTY 1-800-881-2812, Monday through Saturday from 8:00 a.m. to 8:00 p.m.