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:	☐ Transportation ☐ Emergency Care ☐ Out-of-Network Care ☐ Other (please describe below) _____ _____
Provider Address:	
Provider Telephone Number:	( )
Total Amount:	$ _____

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, 3rd 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.