✓MetroPlus**Health**

TRANSPORTATION REIMBURSEMENT FORM

As a MetroPlusHealth Gold member, we want to help you stay healthy.

To help you do this, MetroPlusHealth will reimburse you up to $60 per plan year or the full cost of one ride (whichever is lower) for transportation to see a doctor.

What types of transportation qualify?

All varieties of taxis, car service, rideshare apps such as Uber or Lyft, qualify. Reimbursement is only for single rides via an approved modality (for instance, a $15 metrocard does not qualify).

How do I become eligible?

In order to be eligible, you must be an active subscriber of **MetroPlus Gold.**

How do I obtain the reimbursement?

Obtaining reimbursement is easy! Simply complete and submit this form. You may combine multiple trips into a single reimbursement form, however **MetroPlusHealth** will not accept reimbursement requests which are received by us more than 120 days from the date of the trip.

- **Complete the reimbursement form included with this document**
- **Submit proof of payment.** Acceptable proof includes: Payment receipts, screenshot(s) from a rideshare application, a credit card statement which shows payment for the ride
- **Submit all required documentation no later than 120 days from the date of the trip**
- **Mail** or **fax your form to MetroPlusHealth at the following address:**

MetroPlus Health Plan
Att: Customer Services Department
50 Water Street, 7th Floor
New York, NY 10004

Email: mph_reimbursements@metroplus.org

IMPORTANT: Please complete the form in its entirety or the processing of your claim may be delayed or denied.

If you have any questions, please call our exclusive line for Gold Members at 877.475.3795 (TTY: 711).

PLEASE PRINT. SUBSCRIBER INFORMATION (PERSON WHO HOLDS COVERAGE)**:**			
Member ID Number:	**Last Name:**	**First Name:**	**Middle Initial:**
Address (Number, Street, Apt. #):	**City:**	**State:**	**Zip Code:**

TRIP 1 DETAILS:	
Name of Transportation Provider:	
Date of Trip:	**Trip Amount:**
Medical Office Address:	

TRIP 2 DETAILS:	
Name of Transportation Provider:	
Date of Trip:	**Trip Amount:**
Medical Office Address:	

TRIP 3 DETAILS:	
Name of Transportation Provider:	
Date of Trip:	**Trip Amount:**
Medical Office Address:	

TRIP 4 DETAILS:	
Name of Transportation Provider:	
Date of Trip:	**Trip Amount:**
Medical Office Address:	

TOTAL AMOUNT OF REIMBURSEMENT REQUESTED: _____

Please attach appropriate documentation of payment for the trips for which you are seeking reimbursement, including receipts, screenshots of the rideshare app showing payment, credit card statements.

I certify that the information on the form and all supporting documents are complete, accurate and unaltered.

Member's Signature: _____ **Date:** _____

Alteration or falsification of any information or documentation will be subject to disqualification from participation in the reimbursement program.

If you need assistance because you are hearing impaired and / or speech impaired, please call TTY:711. Please be advised that oral interpretation and written materials in other languages are available as needed. MBR 25.338 6-25

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