Health First
Health Plans

6450 US Highway 1
Rockledge, Florida 32955
E-mail hfhpinfo@health-first.org
www.myHFHP.org

Member Reimbursement Form

Attention Plan Members: This form is to be used for reimbursement of covered services provided in accordance with your Health First Health Plans benefits.

Attention Physicians: Please assist the patient in completing this form to ensure accuracy.

Member Name *(please print)*: _____ **Member ID #** _____

Member Address: _____

_____

Member Signature: _____ **Date:** _____

Date of Service	Procedure Code *(if available)*	Description of Services	Diagnosis Code *(if available)*	Billed Amount

Provider Certification/Verification: I certify that the patient named above incurred these expenses.

Provider Name, Address & Phone Number *(please print)*: _____

_____

_____

Provider Signature: _____ **Date:** _____

By submitting this Member Reimbursement Form, I (member named above) certify that I personally received these services and **request reimbursement according to my plan benefits. Please include an itemized statement and proof of payment with the completed reimbursement form.** Please fax or mail the signed and completed form to:

FAX: 321-434-5655 (Attn: Benefits Reimbursement Unit)

MAIL: Benefits Reimbursement Unit, Health First Health Plans, 6450 US Highway 1, Rockledge, FL 32955

For further assistance, call Customer Service toll-free at 1-800-716-7737 (TTY/TDD relay: 1-800-955-8771) weekdays from 8 a.m. to 8 p.m. and Saturdays from 8 a.m. to noon. From October 1–February 14, we're available seven days a week from 8 a.m. to 8 p.m.

Health First Health Plans is an HMO plan with a Medicare contract. Enrollment in Health First Health Plans depends on contract renewal.

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