Health First Health Plans

Medical Reimbursement Form

Important: Please review the instructions on the last page of this form prior to submitting a request for reimbursement for medical services. This form should not be used to request reimbursement for prescription drugs.

If you need help, please call us at 1.800.716.7737 (TTY: 1.800.955.8771). We are open Monday - Friday 8 a.m. - 8 p.m. and Saturday 8 a.m. – noon, between April 1 and September 30, then Monday - Sunday 8 a.m. - 8 p.m. between October 1 and March 31.

Member Information

First and Last Name:	
Health First Health Plans ID Number:	
Street Address:	
Signature:	Date:

If signed by authorized representative (Appointment of Representative or equivalent written notice on file), please provide the following information:

Name: _____ Relationship to Member: _____

All requests for reimbursement must be submitted by the member or member's authorized representative. By submitting this medical reimbursement form, I (member named above) certify that I personally received these services and request reimbursement according to my plan benefits. Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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Provider Information

First and Last Name:
Street Address:
Phone Number:
Provider Specialty (if known):
Tax Identification Number (if available):
National Provider Identifier (if available):

Information About Services

Date of Services	Diagnosis Codes (if known)	Procedure Codes (if known)	Description of Services	Amount You Paid

Please attach all supporting documentation to the form, including an itemized bill with the following information:

- Date you received the service(s) or item(s)
- Place where you received the service(s) or item(s)
- Description of illness or injury
- Description of each medical service or item you received
- Amount you were charged for each service
- Amount you paid to the provider or supplier

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Instructions

Use this form when requesting reimbursement for expenses related to any of the following:

- Covered medical services for which you paid out-of-pocket
- Dental services
- Hearing services or hardware
- Vision services
- Flu shots from out-of-network providers
- Out-of-country services

To submit a request for reimbursement of out-of-pocket expenses for prescription drugs, use the prescription drug reimbursement form located at myHFHP.org/resources or in your member portal.

Please note the following:

- We will process your request within 30 calendar days if we do not need any additional information from you or your provider, or 60 calendar days if we do need additional information.
- You have 12 months from the date you received the item or service to submit a reimbursement request.
- Reimbursement is based on your plan benefits. We will not reimburse you for any cost-share you may owe for services received.
- If we approve your reimbursement request, you will receive a check in the mail.
- If we deny your reimbursement request, you will get a letter in the mail explaining the reason we denied your request.

Submit your completed form and copies of supporting documents using one of the methods below.

- Mail: Health First Health Plans Claims Department
  P.O. Box 62045
  Phoenix, Arizona 85082
- Fax: 1.866.806.4650
- Secure message to your Care Team; log in at myHFHP.org/login.

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