Health Plans

6450 US Highway 1
Rockledge, Florida 32955
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. **Please include an itemized statement and proof of payment with the completed reimbursement form.**

Member Name *(please print)*: ______________________________ **Member ID #**______________

Member Address: ____

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Signature: ____ **Date:** ________________

Must be signed by member or member's authorized representative. If signed by authorized representative, provide the following information:

Name: ____

Address: ____

Phone Number: (______) _______ - _____________ **Relationship to Member:** _______________

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

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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 fax or mail the signed and completed form, or submit it online:

FAX: 321.434.5655 (Attn: Benefits Reimbursement Unit)
MAIL: Benefits Reimbursement Unit, Health First Health Plans, 6450 US Hwy. 1, Rockledge, FL 32955
MEMBER PORTAL: myHFHP.org/login

For further assistance, please call Customer Service toll-free at 1.855.443.4735 (TTY/TDD relay: 1.800.955.8771) Monday through Friday from 8 a.m. to 6 p.m.

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36194-77150_MPINFO115 (10/2017)