Health First
Health Plans

6450 U.S. Highway 1
Rockledge, FL 32955
myHFHP.org

Medical Reimbursement Form

DOES THIS REIMBURSEMENT REQUEST CONTAIN ANY PRESCRIPTION DRUGS? **YES** **NO**

*(If **YES**, please submit a prescription drug reimbursement form for all prescriptions.)*

An itemized statement is required to process your reimbursement. An itemized statement needs to come from the provider and contain the date(s) of service, diagnosis codes, CPT codes, all applicable charges by line item and total charges. In addition, proof of payment is required for all medical services.

Member ID: _____ Member Name: _____

Member Address: _____

Signature: _____ Date: _____

If signed by authorized representative (Appointment of Representative form or Equivalent Written Notice on file), please provide the following information:

Name: _____ Relationship to Member: _____

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

If you would like to use this form as your itemized statement, please have your provider fill out the information below to certify that the patient named above incurred these expenses:

Provider Name, Address, and Phone: _____

_____

Provider Signature: _____ Date: _____

All requests for reimbursement must be submitted by the member or member's authorized representative. 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. 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.

Attention Plan Members: Use this form for reimbursement of the following covered services provided in accordance with your plan benefits, for example:

- Vision hardware
- Flu shots from out of network providers
- Cruise ship services
- Out of country services

Please include an itemized statement for all services and proof of payment for all medical services with your reimbursement request. An itemized statement needs to come from the provider and contain the date(s) of service, diagnosis codes, CPT codes, all applicable charges by line item and total charges.

Reimbursement requests must be submitted by the member or member's authorized representative. To be an authorized representative, there must be an Appointment of Representative form or Equivalent Written Notice on file.

Reimbursements will be processed within 30 days of receipt of all required documentation.

Please note: Reimbursements for prescription drugs must be submitted on a Prescription Drug Reimbursement Form. This form is available on the member portal.

Once completed you can submit the form to:

Member Portal: myHFHP.org/welcome
Fax: 321.434.5655 (attn.: Benefits Reimbursement Unit)
Mail: Benefits Reimbursement Unit, Health First Health Plans, 6450 US Hwy. 1, Rockledge, FL 32955

- Member reimbursement requests submitted without the required information may cause a delay in payment or may be returned to you.
- The reimbursement request must be submitted within timely filing guidelines from the date of service (6 months).
- Reimbursement is based on plan benefits; cost share may apply to the member's reimbursement.
- Approved reimbursement requests will receive payment with a check on the first page of their EOB
- Denied reimbursement requests will receive a notice of denial to explain the denial reason.

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

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