



75 Vanderbilt Avenue Staten Island, NY 10304 1-844-CPHL-CARES (274-5227)

Member Reimbursement Form

Please complete this form by printing clearly and make sure to sign and date. Supporting documents and itemized receipts must be submitted with this form.

Section 1 – Member Information			
Member Name:		Member ID on card:	
Address:		City:	State: Zip:
Section 2 – Service Details			
Provider of Service (name on receipt):			
Date(s) of Service:			
Amount charged: \$			
Section 3 – Comments <i>(Description / explanation of claim or receipt)</i>			
Section 4 – Signature			
I certify that the above statements and attachments are true and complete to the best of my knowledge and all expenses are for the member stated above.			
x			
Signature		Date	
Section 5 – Instructions			
Mail or fax this form to: Centers Plan for Healthy Living Attn: Reimbursement 75 Vanderbilt Avenue Staten Island NY 10304 Fax: 347-547-7889		Questions? Call Member Services 7 days a week 8 AM- 8 PM 1-844-274-5227 (toll free) TTY: 711	