75 Vanderbilt Ave. 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.
Also, an itemized statement for each medical expense must be submitted with this form.

Section 1 – Member Information			
Member ID on card:	Member Name:		
Address:	City:	State:	Zip:
Section 2 – Service Details			
Provider of Service (name on receipt):			
Date(s) of Service:			
Amount charged: $___________________			
Section 3 – Comments (*Description / explanation of claim or receipt***)**			
Section 4 – Signature			
The above statements and attachments are true and complete to the best of my knowledge.			
x____ *Signature* *Date*			
Section 5 – Instructions			
Fax to: 347-802-4308 for quickest processing. If unable to fax, mail to: Centers Plan for Healthy Living Attn: Claims Department 75 Vanderbilt Ave. Staten Island, NY 10304	**Questions?** Member Services 7 days a week 8 AM - 8 PM 855-270-1600 (toll free) TTY 1-800-421-1220		