

Member Transportation Reimbursement Claim Form

1-866-GO-FOR-HF (1-866-463-6743) (for English, Español, Русский, 中文)

Please complete this form in full. Have your Healthfirst provider sign at the bottom and return it to the address listed above to receive reimbursement. Use one form for each appointment or service visit.

Member /Patient Name		Healthfirst ID #
Date of Birth	Address	Telephone ()
PERSON TO BE REIMBURSED: <input type="checkbox"/> Head of Household/Subscriber <input type="checkbox"/> Member		

REIMBURSEMENT IS FOR COST INCURRED ON _____ (DAY OF APPOINTMENT)

NAME OF PROVIDER SEEN: _____

<p>Check here if you used: <input type="checkbox"/> BUS</p> <p>Number/Route: _____</p> <p>From: _____</p> <p>To: _____</p> <p>Cost Per Person</p> <p><input type="checkbox"/> One Way _____</p> <p><input type="checkbox"/> Transfer Needed + \$ _____</p> <p><input type="checkbox"/> Return Trip + \$ _____</p> <p><input type="checkbox"/> Transfer Needed + \$ _____</p> <p>Total Cost Per Person = \$ _____</p> <p>Number of People on Trip x _____</p> <p>Total Cost for Trip = _____</p>	<p>Check here if you used: <input type="checkbox"/> TRAIN/SUBWAY</p> <p>Line/Route: _____</p> <p>From: _____</p> <p>To: _____</p> <p>Cost Per Person</p> <p>Total Cost Per Person = \$ _____</p> <p>Number of People on Trip x _____</p> <p>Total Cost for Trip = _____</p>	<p>Check here if you used: <input type="checkbox"/> PRIVATE CAR</p> <p>License/Plate Number: _____</p> <p>From: _____</p> <p>To: _____</p> <p>Total Number of Miles Driven: _____</p> <p>11 cents per mile x .11 \$ _____</p> <p>Total Cost for Trip: \$ _____</p>
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Please provide additional information about the money you have spent.

I hereby certify that the information I have provided is true and the expenses claimed are for transportation to covered Healthfirst medical services.

Head of Household or Member(Signature): _____ Date: _____

THIS CLAIM WILL NOT BE PROCESSED UNLESS PROPERLY FILLED OUT BY THE PROVIDER'S OFFICE

HEALTHFIRST PARTICIPATING PROVIDER USE ONLY: I verify that the above Healthfirst member was seen in my office on this day for covered medical services.

Provider Name (Print): _____ Address/Facility/Clinic : _____

Provider Signature/Office Stamp: _____ *Required for payment.