VILLAGECAREMAX

SEE WHAT'S POSSIBLE WHEN HEALTH CARE GETS PERSONAL.

Dear *Member,*

Enclosed is your *Medical Service(s) Reimbursement* form. To ensure no delays in processing please follow the instructions below:

1. Fill out the form in full
2. *Attach copies of each bill/claim and receipt for each payment you have made*
3. *Mail, fax, or email the form along with the supporting bills/claims/receipts to:*

Mail: VillageCareMAX

Attention to: Member Services Department

112 Charles Street

New York, NY 10014

Fax: 212-337-5711

Email: VCMAXmembers@villagecare.org

If you have any questions or need additional help with filling out this form, *please call our Member Services Department at 1-800-469-6292 (TTY 711), 7 days a week from 8:00 am to 8:00 pm.*

VillageCareMAX Member Services

OR

Your VillageCareMAX Team

112 Charles Street
New York, New York 10014
(800) 4MY-MAXCARE
(800) 469-6292
www.villagecaremax.org

John W. Behre, Jr.
Chairman

Emma DeVito
President & CEO

See What's Possible When Health Care Gets Personal.

Medical Service(s) Reimbursement Form

Please complete this form if you paid out of pocket for a covered service(s) or item(s) and you need to ask VillageCareMAX to pay you back for our share of the cost. You must include copies of the bill/claim and receipt for each payment that you have made. If you want more information about how to ask VillageCareMAX to pay you back, call Member Services or read your Evidence of Coverage (Chapter 7, Sections 1 and 2).

Member Information

First Name:_____ Last Name:_____

VillageCareMAX Member ID #: _____

Address: _____

City:_____ State:_____ Zip:_____

Telephone: (_____)_____

Service Information

	Type of service	Date of service	Provider Name	Provider Address	Provider phone	Total paid
1.						
2.						
3.						
4.						
5.						
6.						

Attached Supporting Documentation

☐ Receipt – Proof of Payment

☐ Bill or Provider claim form listing diagnosis & procedures

Member Attestation

By signing below, I certify that I have paid the dollar amount listed for the specified services received while a VillageCareMAX member. I further certify that the documents attached to this form to show proof of payment are accurate, true, and complete. I also understand that any decision made by VillageCareMAX to pay me back will be the amount that the plan is responsible to pay.

Signature _____Date: _____
*If you are the authorized representative, you must sign above and provide the following information:

Name: _____Phone # :(_____)_____

Relationship to Enrollee: _____

Address: _____

Submit Request

Mail, fax or email your request for payment together with any bills or receipts to us at (if emailing your request, please attached documents in .pdf format. Click on the following link to learn how to save a file in .PDF format: https://www.adobe.com/acrobat/online/convert-pdf.html)

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VillageCareMAX
112 Charles Street
New York, NY 10014

Fax: 212-337-5711

Email: VCMAXmembers@villagecare.org

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ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-469-6292 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-469-6292 (TTY: 711) 。