Health First
Health Plans

HEALTH FIRST HEALTH PLANS REIMBURSEMENT FORM

Attention Plan Members: This form is to be used for reimbursement of covered services provided in accordance with Health First Health Plans benefits.

Attention Physicians: Please assist the patient in completing this form to ensure its accuracy.

I. MEMBER INFORMATION AND SIGNATURE

Member Name *(please print)*: ________________________________ **Member ID #:** ____________________
Member Address:____
____

Member Signature: ____ **Date:** __________________________

II. DESCRIPTION OF SERVICES

Date of Service	Procedure Code	Description of Services	Diagnosis Code	Billed Amount

Provider Certification/Verification: I certify that the patient named above incurred these expenses.

Provider Name, Address & Phone # *(please print)*: ____
____

Provider Signature:____ **Date:**__________________________

III. REQUEST FOR REIMBURSEMENT

By submitting this request for reimbursement form, I (member named above) certify that I personally received these services. **I request that payment be made to the following individual *(please check only one)*:**

☐ **Member Named Above** **OR** ☐ **Provider Named Above**

Please either fax or mail the signed and completed form to the attention of the Benefits Reimbursement Unit at:

Fax #: (321) 434-5655
Address: Health First Health Plans, 6450 US Highway 1, Rockledge, FL 32955

IV. ADDITIONAL ASSISTANCE

Members or Providers can contact our Customer Service Department from 8am to 8pm any day of the week at (321) 434-5665 or 1-800-716-7737. TTY users can call the Florida Relay Center at 1-800-955-8771 during the same hours.