



## **TRANSPORTATION REIMBURSEMENT FORM**

**As a MetroPlusHealth Gold member, we want to help you stay healthy.**

To help you do this, MetroPlusHealth will reimburse you up to \$15 per trip (up to four (4) trips per plan year) or the full cost of your ride (whichever is lower) for transportation to see a doctor.

### **What types of transportation qualify?**

All varieties of taxis, car service, rideshare apps such as Uber or Lyft, qualify. Reimbursement is only for single rides via an approved modality (for instance, a \$15 metrocard does not qualify).

### **How do I become eligible?**

In order to be eligible, you must be an active member of **MetroPlus Gold**.

### **How do I obtain the reimbursement?**

**Obtaining reimbursement is easy!** Simply complete this form and submit each time you have a ride to see a doctor. You may combine multiple trips into a single reimbursement form, however **MetroPlusHealth** will not accept reimbursement requests which are received by us more than 120 days from the date of the trip.

- **Complete the reimbursement form included with this document**
- **Submit proof of payment.** Acceptable proof includes: Payment receipts, screenshot(s) from a rideshare application, a credit card statement which shows payment for the ride
- **Submit all required documentation no later than 120 days from the claim period end date**
- **Mail or fax your form to MetroPlusHealth at the following address:**

**MetroPlus Health Plan  
Att: Customer Services Department  
50 Water Street, 7<sup>th</sup> Floor  
New York, NY 10004  
Fax: 212.908.8825**

**IMPORTANT: Please complete the form in its entirety or the processing of your claim may be delayed or denied.**

**If you have any questions, please call our exclusive line for Gold Members at 877.475.3795 (TTY: 711).**

**PLEASE PRINT. SUBSCRIBER INFORMATION (PERSON WHO HOLDS COVERAGE):**

<b>Member ID Number:</b>	<b>Last Name:</b>	<b>First Name:</b>	<b>Middle Initial:</b>
<b>Address (Number, Street, Apt. #):</b>	<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>

**TRIP 1 DETAILS:**

<b>Type of Transportation Provider:</b>	
<b>Date of Trip:</b>	
<b>Reimbursement Amount Being Requested:</b>	

**TRIP 2 DETAILS:**

<b>Type of Transportation Provider:</b>	
<b>Date of Trip:</b>	
<b>Reimbursement Amount Being Requested:</b>	

**TRIP 3 DETAILS:**

<b>Type of Transportation Provider:</b>	
<b>Date of Trip:</b>	
<b>Reimbursement Amount Being Requested:</b>	

**TRIP 4 DETAILS:**

<b>Type of Transportation Provider:</b>	
<b>Date of Trip:</b>	
<b>Reimbursement Amount Being Requested:</b>	

**TOTAL AMOUNT OF REIMBURSEMENT REQUESTED:** \_\_\_\_\_

**Please attach appropriate documentation of payment for the trips for which you are seeking reimbursement, including receipts, screenshots of the rideshare app showing payment, credit card statements.**

**I certify that the information on the form and all supporting documents are complete, accurate and unaltered.**

**Member's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Alteration or falsification of any information or documentation will be subject to disqualification from participation in the reimbursement program.

If you need assistance because you are hearing impaired and / or speech impaired, please call TTY: 711. Please be advised that oral interpretation and written materials in other languages are available as needed. MBR 22.325 11-22

