

Request for Retroactive Reimbursement

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| **INSTRUCTIONS:** This form should be completed by a VNS Health member who is asking to be reimbursed by VNS Health for services that were provided and were paid for by the member or his/her family. Please fill in all blanks below and attach bills, receipts, and/or other documentation to support this request. You may fax this form to (646)524-8338 or email ChoiceCCSeniorMSR@vnshealth.org to the VNS Health Plans Contact Center.**Note**: VNS Health policies require a member to get approval in advance for services that are covered by the program. Please be sure to include an explanation of why this could not be done in your situation. You will be informed of VNS Health’s decision about your request within 60 days after we receive this form.  |
| Member’s Name |  |
| Member’s Address(Street, Borough, Zip) |  |
| Telephone Number |  |
| Subscriber ID |  |
| Description of FLEX Service or Item  |  |
| Date of Service or Purchase |  |
| Total Cost (Attach bills and/or receipts) |  |
| Reason Why This Was Not Approved in Advance |  |
| Signature of Person Completing Form  |  |
| Phone No. of Person Completing Form  |  |
| Date Form Completed |  |
| ***[OFFICE USE ONLY – DO NOT WRITE IN SHADED AREA]*** ***Date Received Date Reviewed***  ***Reviewed by Telephone*** |

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