EmblemHealth®

Over-the-Counter (OTC) Member Reimbursement Form

You must use in-network health care professionals for services. If you cannot do so due to extraordinary circumstances, please use this form to file a claim for reimbursement of out-of-pocket costs of your covered OTC benefits, if applicable. We will review your request.

Member's Last Name	**Member's First Name**	**Member ID No.**

Member's Address

Street No.		
City	State	ZIP Code

OTC retailer information

Business Name	**Phone**

Business Address

Street No.		
City	State	ZIP Code

Total Amount Paid $:	**Date of Service**

Send this completed form with an itemized receipt for each purchase to:
EmblemHealth Claims Department
55 Water Street
New York, NY 10041-8190

Please retain a copy of this form and your receipt for your own records. If you have questions, call us at the number on the back of your member ID card. A Customer Service representative will be happy to help.

You can also visit us at **emblemhealth.com/medicare**.

Print Reset Form