EmblemHealth®

Over-the-Counter (OTC) Member Reimbursement Form

Please use this form to file a claim for reimbursement of out-of-pocket costs of your covered over-the-counter (OTC) plan benefits, if applicable.

Member's Last Name	**Member's First Name**	**Member ID #:**

Member's Address:

Street No.		
City	State	ZIP Code

Over-the-counter 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**.

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