Enrollee Name ______________________________

Enrollee MIF ID # NYS ___________________________

Payment will be issued to the enrollee.
Enrollee is responsible for reimbursing the provider.

Questions on how to fill this out?
Please call Customer Service:
1-855-NYMIF33 (855-696-4333) and press Claims Option

GENERAL REIMBURSEMENT FORM - USE FOR:

- Provider services, including office co-pays, co-insurance, and deductibles
- Respite Care
- Supplies

Instructions

- Add as many/few lines as you would like (no other alterations can be made)
- Each service/item must be broken out on individual rows
- Must include all requested data per **all** column headers.
- Attach **all** itemized receipts which must include providers printed name & signature, address, phone number, date(s) of service, and paid amount
- Respite Care: If more than 1,080 hours are provided in a calendar year, prior approval is required
- Co-pay receipts must be on office or pharmacy letterhead
- Additional forms may be used if necessary
- Send completed forms to NY_DOH_MIF@pcgus.com or mail to:
  MIF c/o PCG, P.O. Box 784 Greenland, NH 03840-0784

Provider's Last Name	**Providers First Name**	**Providers Address**	**Place of service** (Ie. Home, Office, Retail Store)	**Date of Service From**	**Date of Service To**	**Description of Service/Item:** As shown on receipt or as described by provider	**Total Unit of Service/Item** (Ie. Days, Hours, Quantity)	**Total Amount Billed ($)**

I certify the information given is accurate and no items and/or services have been reimbursed or are pending reimbursement by another source(s)

SIGNATURE ______________________________ RELATIONSHIP TO ENROLLEE ______________________________

PRINT NAME ______________________________ DATE: ________/_________/_________