Student Plans Reimbursement Request

Use this form to request reimbursement of Student Health Center and Flu Clinic services.

Please print all information below. See the reverse side for information about completing this form.

Section 1: Member Information

Member's Name *(last, first, middle initial)*

MVP Subscriber No. 0 0

Street Address | City | State | Zip Code

Phone No.
( )

Section 2: Reimbursement(s) Requested

Check all services for which you are requesting reimbursement. Provide all information requested below and included all receipts with this request as proof of your paid expense.

Service(s)	Date of Service	Diagnosis Code	Amount Paid	Date Paid	*(Office Use Only)* CPT
☐ **Injection(s)**			$		915RX
☐ **Flu Shot at a Flu Clinic**			$		90658
☐ **Flu Shot at Student Health Center**			$		90658
☐ **Other**			$		

Section 3: Service Provider's Information

College (Health Center) Name

Phone No.
( )

College Street Address | City | State | Zip Code

College (Health Center) NPI No.

College (Health Center) Tax ID No.*

** For Hamilton College Student Health Center, please use Tax ID No. **15-0532200**.*

Section 4: Certification and Authorization *(this form must be signed below)*

By signing below, I certify that the above statements are correct. I understand that any person who knowingly and with intent to defraud any insurance company or other person, files an application or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Subscriber's Signature *Date*

How to Submit Your Student Plan Reimbursement Request

You must pay for the service(s) before submitting a request for reimbursement and provide proof of that payment. For each reimbursement, you must include the following:

1. A copy of an itemized bill, statement, debit/credit card statement, or receipt that is preprinted, stamped, or on school letterhead that includes the service provider's name and address.
2. Documentation from the service provider that includes all of the following information:
   - Name of the provider
   - Type of service provided
   - Date service was rendered (start date)
   - Your out-of-pocket cost for the service, including date(s) of all payments
   - Name of the person receiving the service provided

Reimbursement requests that are not submitted according to these instructions will be returned for you to correct and re-submit.

Submit your completed reimbursement request and all required documentation to MVP using one of the following:

- **Mail** to CLAIMS SUBMISSION, MVP HEALTH CARE, PO BOX 2207, SCHENECTADY NY 12301-2207
- **Email** to **submitclaims@mvphealthcare.com**
- **Fax** to **518-395-1395**
- **Online** at **mvphealthcare.com**. *Sign In* to your online account and select *Medical Claims Reimbursement*. You may submit medical only claims online. Only current MVP members age 18 and older may submit medical claims online.

Please allow 4–6 weeks for reimbursement.

MVP Health Care® is dedicated to providing prompt and accurate reimbursements to our health plan participants. By following these instructions and completing the reimbursement request completely, you will help us process your request in a satisfactory manner.