# Court Officers Benevolent Association of Nassau County, Inc.
## Supplemental Prescription/Medical Reimbursement Program Claim Form

**It is the member's responsibility to ensure your claim form is received by Healthplex on or before April 15th. It is suggested that you maintain a copy of your completed application and/or enclosures. You can view your record at www.healthplex.com to see if your claim is posted, or you can call the Healthplex Customer Service Department at (888) 468-5178.**

To receive Supplemental Prescription/Medical reimbursement applicants must be a COBANC member at the time of service, submission and review of application and disbursement of funds.

- Complete this form. All claims must be submitted by April 15th for payments of the prior calendar year's claims.
- Attach an itemized bill or receipt from the Provider of Service for all eligible expenses containing the following information. Cancelled checks are not acceptable.
  - Name of person and date of expense
  - Amount of patient copayment
  - Name of provider rendering service
- Members may submit paystubs or receipts that show the total amount outlayed for their health insurance.
- Mail completed form and attachment to:

  **Attention**: Claims Dept.
  PO Box 9255
  Uniondale, NY 11553-9255
  Providers Call – (888) 468-2183 Press Option 1 for IVR
  Members Call – (888) 468-5178

### Member Information – PLEASE PRINT

Employment Status: ☐ Active ☐ Retiree ☐ Part-Time ☐ Check here if this is a new address

Member Name_____ Member Identification # _____

Member Address_____
Street

_____
City State Zip Code

### Prescription/Medical Copayment Information

| Name | Date of Birth | Relationship to Member | Dates of Prescriptions/ Medical Visit | Provider's Name | Amount of Claim |
|---|---|---|---|---|---|
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| | | | | | |

**Total** _____

I hereby request payment for the above claimed expenses. I certify that either my eligible dependent(s) or I have incurred these expenses and have not been previously reimbursed. **I understand that this must be returned to Healthplex by April 15th to receive payment.**

Member's Signature _____ Date _____