



**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 15<sup>th</sup>. It is suggested that you maintain a copy of your completed application and/or enclosures. You can view your record at [www.healthplex.com](http://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 15<sup>th</sup> 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 that show the total amount outlayed for their health insurance.
- Mail completed form and attachment to:

Healthplex, Inc.  
333 Earle Ovington Blvd., Suite 300  
Uniondale, NY 11553-3608  
Providers Call – (888) 468-2183 Press Option 1 for IVR  
Members Call – (888) 468-5178

**MEMBER INFORMATION – PLEASE PRINT**

Employment Status:  Active     Part-Time     Retiree     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
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**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 15<sup>th</sup> to receive payment.

Member's Signature \_\_\_\_\_ Date \_\_\_\_\_