HUDSON VALLEY COMMUNITY COLLEGE
CDPHP CO-PAY REIMBURSEMENT FORM

Subscriber Name: _____

Social Security #: _____

Member Name: _____
(If different from subscriber)

Date Submitted: _____

Contact Information: _____
(Phone or email)

Please attach receipts that show the co-pay amounts, provider and dates of service.
All claims must be submitted for consideration within 20 months from date of service.
Cash register receipts that do not indicate what the payment was for are not acceptable.

Your co-pay reimbursement must total a minimum of $20 before submissions can be made.

Submit this form and all attachments to:

'URS RII 2IILFH RI +XPDQ 5HVRXUFHV $GP
(PDLO +5#KYFF HGX

+XPDQ 5HVRXUFHV will verify coverage and calculate amounts owed. Payment will be made by HVCC Checks will be processed once each month.