New York State

Medical Indemnity Fund

Please submit the completed form and receipts to:

NYS Medical Indemnity Fund
c/o AliCare
P.O. Box 5441
White Plains, NY 10602-5441
Fax: (212)844-7796
Email: MIF@dfs.ny.gov

New York Medical Indemnity Fund
General Reimbursement Claim Form

Name of Enrollee: _____ **Enrollee ID #:** _____

Check box (es) below which apply to each item/service listed

Date of Service	Item/Service to be reimbursed	Copay Deductible Co-Insurance (circle all that apply)	Therapy	Prescription/ over the Counter	Durable Medical Equipment	Nursing	Respite	Other	Cost of Item/Service
									$
									$
									$
									$
									$
									$
									$

All SUPPORTING DOCUMENTS MUST BE ATTACHED **TOTAL COST $_____**

I CERTIFY THE INFORMATION GIVEN IS ACCURATE AND THAT NONE OF THESE ITEMS HAVE BEEN REIMBURSED BY ANY OTHER SOURCE FOR ANY AMOUNT, NOR ARE THEY PENDING REIMBURSEMENT FROM OTHER SOURCES.

Relationship to Enrollee: _____ **Print Name**: _____

Signature: _____ **Date**:_____ _____