NASSAU COUNTY SMART SAVINGS PROGRAM
c/o Pamela D'Apuzzo
VMG Health
PO Box 136
Lindenhurst, NY 11757

NASSAU COUNTY SMART SAVINGS PROGRAM
REIMBURSEMENT FORM

PRIMARY INSURED INFORMATION

PRIMARY INSURED _____
Last Name First Name Middle

PRIMARY INSURED'S ADDRESS_____

_____

Telephone Number _____ Is this a change of address? Yes ___ No ___

Insurance Card # _____

PATIENT INFORMATION

1) PATIENT'S NAME_____

PATIENT'S ADDRESS_____
(If different from primary insured's address)

RELATIONSHIP TO PRIMARY INSURED_____ DATE OF BIRTH_____

SEX: M___ F___

PATIENT INFORMATION

2) PATIENT'S NAME_____

PATIENT'S ADDRESS_____
(If different from primary insured's address)

RELATIONSHIP TO PRIMARY INSURED_____ DATE OF BIRTH_____

SEX: M___ F___ *Use a separate sheet for additional patients

Note: Effective 1/2023 Active PBA, SOA, DAI, CSEA & effective 1/2024 Active COBA, Claimants must provide proof of out-of-pocket expenses totaling $4,000.00 in medical costs that would have otherwise been covered by a second

family insurance plan. All other active and retired claimants must exceed the $2000 threshold. See reimbursement procedures for more information.

Expenses

Patient	Date of Service	Out-of-Pocket Expenses (i.e. co-pays, deductibles)	Reimbursement Amount

*Attach additional sheets if necessary

The undersigned certifies as follows: To the best of my knowledge and belief, the statements made in this Reimbursement form are true and complete. These statements are being made for reimbursement of eligible expenses under the Smart Savings Program incurred during the respective year for eligible plan participants. I certify that I have exhausted the $4,000.00/$2,000.00 buyback amount. I further certify that I have incurred additional expenses exceeding $4,000.00/$2,000 for expenses that would have otherwise been covered by a second family health insurance plan.

SIGNATURE _____ DATE _____

Mail to: **NASSAU COUNTY SMART SAVINGS PROGRAM**
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VMG HEALTH
PO BOX 136
LINDENHURST, NY 11757
(631) 231-0505