

# Contraceptive Management Mobile Application Reimbursement Form

This form is to be used only for the reimbursement of Federal Drug Administration (FDA) approved mobile application(s) downloaded for contraceptive management, in accordance with federal regulations.

You can use this form to request reimbursement for the purchase of the application which has been authorized by the FDA.

- This form is for the FDA Authorized contraceptive management application purchased by you for monthly or annual reimbursement.
- Print your responses in black or blue ink.
- Include proof of payment (such as a paid receipt) that includes the name of the application along with this completed form. If we don't receive the required information, your request will not be processed.
- Send the completed form and proof of payment to NYCE PPO Plan, P.O. Box 21534, Eagan, MN 55121, or you can complete this form and submit it online using the claim submission tool in the secure member portal on [nyceppo.com](http://nyceppo.com).

## Subscriber/policyholder information

Subscriber/policyholder full name \_\_\_\_\_

Member ID \_\_\_\_\_ Group number \_\_\_\_\_

Date of birth     /     /      
MM DD YYYY

Street address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Is this a new address?      Yes      No

Phone number     -     -          Email address \_\_\_\_\_

Patient name \_\_\_\_\_ Patient date of birth     /     /      
MM DD YYYY

## Information about your application purchase

Is this reimbursement for the monthly fee or annual fee? \_\_\_\_\_

Purchase date(s)     /     /            /     /            /     /      
MM DD YYYY    MM DD YYYY    MM DD YYYY

Total amount submitted for reimbursement \$ \_\_\_\_\_

## Member signature

Signature \_\_\_\_\_ Date     /     /      
MM DD YYYY

When I sign above, I am stating that the information on this form is correct. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

## Ready to send the completed form?

Please send the completed form and proof of payment to NYCE PPO Plan, P.O. Box 21534, Eagan, MN 55121, or you can complete this form and submit it online using the claim submission tool in the secure member portal on **nyceppo.com**.

Before you put it in the mail or submit online, make sure you:

- Have completed and signed the form
- Have included proof of payment, such as a paid receipt
- Keep a copy of everything you send us



### Questions? We're here to help.

If you have any questions, please call Member Services at **212-501-4444** (TTY: **711**)

#### For Internal Use Only:

Diagnosis code: Z30.8

Place of Service: 10 (OF)

HCPCS Code: A9293

Tax ID – 999999993

Units: 1