# Member Restitution Form

MVP Health Care® (MVP) recently reached an agreement with the New York State Office of the Attorney General. As part of a settlement, MVP will reimburse current or former members who may have paid out-of-network cost-shares for mental health services received between January 1, 2020 through August 26, 2025.
This may include:

- Services billed as out-of-network by a provider who was listed as an in-network provider in the MVP Provider Directory; or
- If you were unable to get a timely appointment with an in-network mental health provider.

**If you believe this applies to you, use this form to submit claims for review.** Submit one form for each member for each provider seen.

If your claim is eligible for reimbursement, you will be reimbursed in accordance with the terms of your Subscriber's Contract at the time of service. Please note that the determination will be final, and no appeal rights will be available.

## Submission Instructions

To submit your request, email this completed form and all supporting documents to **restitution@mvphealthcare.com** or mail them to:

MVP Health Care
ATTN: Restitution Department
625 State St.
Schenectady, NY 12305

**Completed restitution forms and all necessary documents must be emailed or postmarked no later than May 6, 2026.**

If you need additional printed forms, visit **mvphealthcare.com/restitution** or call the number on the back of your MVP Member ID card.

This form should NOT be used to submit for reimbursement for member claims during this current plan year.

## Member Information:

Member Name

Member Date of Birth

MVP Member ID *(at time of service)*

## Mailing Address:

Address 1

Address 2

City

State

Zip Code

## Provider Information: *Please submit one form per provider seen.*

Name of Provider

Provider Address

Date(s) of Service

***Select the reason you saw this provider:***

- ☐ **Provider was listed in MVP Directory as in-network but billed as out-of-network**
- ☐ **Desired in-network provider was not accepting new patients**
- ☐ **Could not find an in-network provider near me**
- ☐ **Desired in-network provider could not see me in the timeframe I needed**
- ☐ **Could not find an in-network provider that was able to treat my condition**
- ☐ **Other (please explain)**

**Describe the steps taken to see an in-network provider:**

**The following must be included with your submission. Check to indicate they are included:**

- ☐ **Copy of bill from provider**
- ☐ **Proof of payment to provider (e.g., receipt)**