Name: _________________________________

Member ID: _____________________________

I may have incurred out-of-pocket costs related to out-of-network medical services because of alleged previous overpayment(s) to my providers (for example, because I received an Explanation of Benefits (EOB) with the code “860 ADJUST/VOID CLAIM-ABNORMAL-EFFECTS 1099 AMT & NOT REMITS”).

Date(s) of bill(s): _____________________

Date(s) of payment(s): _________________

I have attached the following:

_____ Evidence of payment of a provider’s bill, including any interest, fees, or penalties connected to the payment of the bill.

_____ Evidence of payment to a collection agency on behalf of a provider, including any interest, fees, or penalties connected to the payment.

_____ Evidence of a garnishment or lien against me arising from an unpaid provider bill.

_____ Evidence of court costs or allowed attorney’s fees paid in a legal proceeding commenced against me.

_____ Other: ____

I am providing my contact information for further correspondence on this matter:

Address: ____

City: ___________________________________ State: __________ Zip: ______________

Phone: _________________________________

Mail to:
EmblemHealth
Attn: DOL Settlement
55 WATER ST STE CONC-L
NEW YORK NY 10275-0718