CLAIM FORM

Today's Date: _____/_____/_____ # of pages: _____ Plan Year: 20____

☐ New Claim ☐ Response to Claim Denial

Employer Name/Division Name:	Employee Name:	
Address: ☐ Please check if change of address		
Social Security Number:	E-mail Address:	Home Phone: Work Phone:

☐ **Medical Expense Reimbursement Account** **Total Amount Requested:**_____

- Enclose insurance company statement or itemized bill from provider showing date of service, services rendered, provider of service, amount paid and, if applicable, amount covered by insurance.
- Prescription claims MUST include the Rx number and pharmacy receipt, not cash register receipt.
- Allowable reimbursement for mileage expenses.

☐ **Dependent Care Reimbursement Account** **Total Amount Requested:**_____

Note: you MUST include the provider Tax ID Number in the service provider column in the table below. If you use the account to pay for the cost of a babysitter, you must provide the babysitter's Social Security Number. If you cannot remit a copy of your bill/contract, your daycare provider must sign on the line below in lieu of submitting a receipt.

Provider Signature: _____ **Date:**_____

☐ **Individual Premium Reimbursement Account** **Total Amount Requested:**_____

Note: please attach proof that employee owns policy.

☐ **Adoption Assistance Reimbursement Account** **Total Amount Requested:**_____

☐ **Parking Reimbursement Account** **Total Amount Requested:**_____

☐ **Transportation Reimbursement Account** **Total Amount Requested:**_____

☐ **Health Reimbursement Account** **Total Amount Requested:**_____

	Date of Service	Employee, Spouse or Dependent	Amount Requested	Type of Service (R_x, co-pay, dental expense, etc.)	Service Provider Number/ R_x Number
1.					
2.					
3.					
4.					
5.					

I certify that the above listed expenses have been incurred by me or by my spouse or dependent(s) and that they have not been reimbursed under any other health plan; furthermore, I will not seek reimbursement of the expenses under any other health plan.

Employee's Signature:_____ Date: ___/___/___

Revised 2/3/2012