

Request for Reimbursement Form

The Health care reimbursement Dependent care reimbursement For example, doctor co-pay, pharmacy co-pay, doctor visit, over the counter medication, etc. Cancelled checks or balance forward statements are not acceptable bills. Esupport data. When applicable, attach a copy of your Explanation or Summance Company. To the best of my knowledge and belief, my statements in this Request for Reimbursement are complete and true. I am claiming reimbursement only or eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not claim the expenses as an income tax deduction. I will not seek reimbursement for the expense(s) under any other plan covering health benefits.	Telephone ()	
Change of address (please check this box if new or changed) Mailing Address Number and Street EXPENSE ITEMS Date(s) of Service Type* Description ** (sees below) 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. (Attach additional sheets if necessary) H - Health care reimbursement For example, doctor co-pay, pharmacy co-pay, doctor visit, over the counter medication, etc. Reminder: Cancelled checks or balance forward statements are not acceptable bills. E support data. When applicable, attach a copy of your Explanation or Summ ance Company. To the best of my knowledge and belief, my statements in this Request for selimbursement are complete and true. I am claiming relimbursement or legible expenses incured during the applicable plan year and for elimbursement are complete and true. I am claiming relimbursement to been previously reimbursed under this or any other benefit plan and will not claim the expenses in an income tax deduction. I will not seek reimbursement for the expenses (s) under any other plan covering health benefits.		
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Provider's Signatur		e provided for the amount f service:
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