

Health Reimbursement Arrangement

DEDUCTIBLE REIMBURSEMENT REQUEST

"Please Print"

Name of Employer:	
Name of Employee:	SSN: (required) - -
Address:	Address Change: <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State/Zip:	Email Address:

Expense Information - Please Print

Please complete the following information **and** attach the required substantiation for each medical expense for which you are requesting reimbursement. Required claim substantiation is as follows:

- ❖ For expenses/services that apply to a Deductible the Explanation of Benefits (EOB) provided by your insurance company is required.

<u>Dates of Service</u>	<u>Amount Requested</u>	<u>Provider Name</u>	<u>Type of Service</u>
___/___/___ to ___/___/___	\$ _____	_____	_____
___/___/___ to ___/___/___	\$ _____	_____	_____
___/___/___ to ___/___/___	\$ _____	_____	_____
___/___/___ to ___/___/___	\$ _____	_____	_____
<u>Total Amount Requested</u>	\$ _____	<u>only those expenses incurred prior to the date of this request will be processed</u>	

Participant Acknowledgement: Reimbursements will only be made for expenses incurred **prior** to the date of the Reimbursement Request. An expense is considered **incurred** when the service is provided **not** when you make payment to your provider. Reimbursements will only be made when accumulated claims exceed \$25.00. The \$25.00 requirement is waived at the end of the plan year. All payments and correspondence will be issued directly to you.

I hereby certify that this information is, to the best of my knowledge, correct and that I have not or will not be reimbursed by any other health plan or program nor will the expense(s) be used as basis for a tax deduction. Claim documentation cannot be returned – please keep copies for your records.

Employee Signature: _____ **Date:** _____



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