Request for Reimbursement

Please use this form to request reimbursement for:

- Eligible expenses not covered by any health or dental insurance.
- The unpaid balance of a health or dental care claim submitted under an employee's group plan.
- Dependent day care expenses.

Employe	ee Name	Social Security #									
Telepho	ne # (Work)	Work Location:									
Provider of Service Person Receiving			Relationship to You	Date Expense	Reimbursement						
		Service	(the employee)	Incurred	Type*	Request Amount					
* Expense	Type Code: M-Medical; H-Hearing; D-D]			\$						
P-Prescription Drug; C-Dependent Care			Total	Total Reimbursement Requested							
I certify	that:										
1.		e expenses claimed a	bove are not eligible	for reimburseme	ent by any i	nsurance carrier or					
	The health and/or dental care expenses claimed above are not eligible for reimbursement by any insurance carrier or employer-sponsored health or dental care plan.										
2.	The dependent day care expense claimed above enable me to be gainfully employed, are attributable to the care of a										
	qualifying individual, and have not been paid to a dependent. I further certify that these dependent day care										
	expenses submitted under this claim and when combined with dependent day care expenses reimbursed previously										
	this year do not exceed my (o			•							
3.	3. The expenses claimed above have not been, and will not be, taken as a credit or deduction on my personal income tax										
	return.										
4.	4. Where I have not included the address and taxpayer identification number of each dependent day care provider list										
above, I have done so because: a. I submitted it earlier this year, or b. The provider is a non-profit religious, sharitable or educational organization (under Section E01/s)//											
										 b. The provider is a non-profit, religious, charitable or educational organization (under Section 501(c)(3)) or c. I was unable to obtain this information after diligently trying to obtain it. 	
	c. I was anable to obta		arter unigently trying	to obtain it.							
Date:		Employee Signatu	ire:								
						_					
-	endent day care expenses ONL	, send copies of reco	ords supporting each	listed item of ex	pense or ha	ave your Day Care					
Provider	sign the statement below:										
I provide	ed the Day Care services as state	ed above	Tax ID:								

__ Day Care Provider Signature: __

Instructions for Completing Your Claim Form

Please read these directions before mailing your form. If this form is not completed correctly, your request will be returned.

- 1. In section "A," fill in your name and social security number.
- 2. Complete the following information in section "B::
 - Provider of Service: Enter the name of the person or facility that provided the service.
 - Person Receiving Service: Enter the name of the eligible person covered under the claim.
 - Relationship: If the claim is for you, enter "self"; if the claim is for a dependent, enter "spouse," "child," or "parent," whichever is applicable.
 - Date Expense Incurred: Enter the date the service was provided (not the date of the bill).
 - **Expense Type:** Enter the code for the type of expense using the following:

M-Medical

D-Dental

P-Prescription Drugs

H-Hearing

V-Vision

C-Dependent Care

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E	mployee Name			Social Security #			
4	elephone # (Work)			Work Location:			
Ī	Provider of Service	Person Receiving Service	Relationship to You (the employee)	Date Expense Incurred	Type'	Reimbusement Request Amount	
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	Dipense Type Code: M-Madial; H-Mani Prescription Drug: GDependent Care	ng: D-Dentel: V-Vision:		Seimbunement			
) .	this year do not exceed . The expenses claimed at return. Where I have not include above, I have done so be a. I submitted it. b. The previder is c. I was unable to	eith or dental care plan, expense clisimed, shocke, of d have not been paid to er this claim and when or my [or, if married, the low sove have not been, and ed the address and taxpa ecouse:	coable one to be gaind dependent. I further imbined with depend will not be, taken as a yer identification num heritable or education etter difigently trying	ulk employed, a certify that the ent day care ex- ers) earned inco- credit or deduct their of each dep- let organization to obtain it.	ge attribut se depende pendes rein ime. Sion on my endent da junder Sec	able to the care of a nt day care ibursed previously personal income tax y care provider listed	
	or dependent day care expenses ravider sign the statement below		ords supporting each	listed item of ex	pense or h	ave your Day Care	
		s stated above	Tex ID:			100	
) [Day Care Provider	Signature:				

- **Reimbursement Amount:** Enter the amount requested for reimbursement. (NOTE: if you have a Health Care Explanation of Benefits to attach, enter the difference between the amount paid by the health care plan.)
- 3. In section "C," be sure to date and sign the form or your claim will be delayed. No claims can be processed without a signature. If this is a dependent day care expense, complete the dependent day care expense information in section "D."
- 4. **Documentation Needed:** You must attach copies of required documentation to receive reimbursement. If documentation is not correct, the request will be returned to you.
 - For expenses covered by your insurance company or health care plan, attach a copy of the Explanation of Benefits (EOB) form received from the insurance company or administrator. For prescription drug expenses, submit a copy of the drug label.
 - For eligible medical expenses not covered by a health care plan, attach a statement of expense showing the type of service, the incurred date and the amount of expense: For example, a physician's bill or itemized receipt.
 - Cancelled checks are not acceptable documentation.
- 5. Submit completed and signed form (with documentation attached).