Health Care Reimbursement Request

Use This Form For Health Care Expenses Incurring September 1, 2004 through August 31, 2005

FILING INFORMATION

- ***ATTACH A COPY OF THE PROVIDER'S BILL AND/OR YOUR INSURANCE COMPANY'S "EXPLANATION OF BENEFITS" SHOWING*:**
  - *Name of the service provider and type/description of service if not listed on bill;*
  - *Date the service was incurred;*
  - *The amount charged for the service, not just the amount paid;*
  - *Prescription Drugs must show the name of the drug being dispensed.*
- ***ATTACH A DETAILED DATED RECEIPT NAMING THE PRODUCT FOR ELIGIBLE OVER-THE-COUNTER MEDICINES/PRODUCTS***

- **Sign this form and mail it, or send it through the Pony, to the address listed at the bottom of the form.**
- **You may not claim any amount reimbursed to you by the Plan as a deduction or credit on your Federal Tax Return.**
- **One Health Care Reimbursement Request Form may be used to file for multiple expenses.**
- **Minimum claim reimbursement is $25.00. However, at the end of the Plan Year or at any other time when coverage is fully terminated, a claim can be made for less.**
- **You may want to keep a copy of your claim for your personal record.**

STATE PPO PARTICIPANTS MUST HAVE AN EXPLANATION OF BENEFITS ATTACHED TO CLAIM.

REQUESTS FILED WITHOUT PROPER DOCUMENTATION WILL BE RETURNED FOR NECESSARY INFORMATION.

Only One Claimant Per Claim — **CLAIM INFORMATION (SEE WORKSHEET ON BACK)** — **Only One Claimant Per Claim**

Name of Employee: _____
(Last) (First) (MI)

Social Security Number: _____ Home Phone: _____

Patient/Eligible Dependent
for Whom Services Were Provided: _____
(Last) (First) (Relationship)

Total Amount Requested: _____ (The Amount Requested is the amount ***after*** any insurance payment.)

To the best of my knowledge, my statements on this Request for Reimbursement are complete and true. I am solely responsible for the validity of claims submitted to my Flexible Spending Account. I am claiming reimbursement only for eligible expenses incurred during the Plan Year shown above. ***I certify that these expenses have not been reimbursed by any other source or insurance, nor will these expenses be reimbursed by any other source or insurance****.*

_____
Employee Signature *Date*

Jefferson Federation of Teachers
HEALTH AND WELFARE FUND
POST OFFICE BOX 6137 • METAIRIE, LA 70009-6137
PHONE (504) 455-7261 • FAX (504) 455-7267

Claim Worksheet

You ***ARE NOT*** required to complete this worksheet. It is provided as a convenience to help organize your claim charges and it assists the Fund staff in an efficient processing of your claim.

ATTACH A COPY OF THE PROVIDER'S BILL AND/OR YOUR INSURANCE COMPANY'S "EXPLANATION OF BENEFITS" SHOWING:

- *Name of the service provider and type/description of service if not listed on bill;*
- *Date the service was incurred;*
- *The amount charged for the service, not just the amount paid;*
- *Prescription Drugs must show the name of the drug being dispensed.*

ATTACH AN ADEQUATE RECEIPT NAMING THE MEDICINE OR PRODUCT, THE DATE, AND THE AMOUNT PAID FOR ELIGIBLE OVER-THE COUNTER (OTC) CLAIMS

STATE PPO PARTICIPANTS MUST HAVE AN EXPLANATION OF BENEFITS ATTACHED TO CLAIM.

REQUESTS FILED WITHOUT PROPER DOCUMENTATION WILL BE RETURNED FOR NECESSARY INFORMATION.

Date of Service	Description	Amount

Total _____