

Health Care Reimbursement Request

Use This Form For Health Care Expenses Incurring
September 1, 2005 through August 31, 2006

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

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