Request for Reimbursement
CLAIM FORM

Please check which account the enclosed claims are to be reimbursed from:

π **Health Reimbursement Account** π **Flexible Spending Account/Dependent Care**

Employer Name:			
Employee Name:	Last First MI	**SS#**	
Employee Address:	Street City State ZIP	**PHONE**	( )

π **Please check if this is a new address**

Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this claim.

* Information below must be completed

MEDICAL EXPENSE CLAIMS

Date of Service MM/DD/YY	Patient Name	Patient's SS#	Relationship	Name of Provider	Description of Service	Claim Amount
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$
					Total:	$

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ **Date:** _____ /_____ /_____

For Fastest Reimbursement, Fax to 740-947-6068
Or mail to: Patrick Benefit Administrators
P.O. Box 520 Piketon, Ohio 45661