Reimbursement Claim Form – Oregon CUSD #220

EMPLOYEE NAME: _____ EMPLOYEE SSN: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

Does the patient have secondary coverage? Yes / No

If yes, please provide the name of the carrier:_____

MEDICAL/PRESCRIPTION EXPENSES - ATTACH A COPY OF EOB TO CLAIM FORM

Item	Patient Name	Date (s) of Service	Provider (Person or Business)	Reimbursement Required
1				
2				
3				
4				
5				

To the best of my knowledge and belief, my statements in the Request of Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for my eligible dependents and myself. I certify that these expenses have not been and will not be reimbursed under any other employer sponsored benefit plan (including any HSA) and will not be claimed as an income tax deduction. In addition, I certify that these expenses have not been previously reimbursed under this plan. I understand and authorize that my plan account will be reduced by the amount of the requested reimbursement.

_____ _____

Employee Signature* Date*

*Note: Form must be signed and dated in order to process this claim. **MINIMUM CHECK AMOUNT $25.00**

Reminders: Provide complete and proper documentation for all expenses submitted. Keep copies of everything submitted for reimbursement. All rejected claims must be resubmitted with proper documentation

Mail / Fax / Email requests for reimbursements to:
Mailing Address: PO Box 880, Freeport, IL 61032
Fax: (815) 599-7066
Email: NIHPCustomerService@nihp.com