HEALTHCARE REIMBURSEMENT PLAN CLAIM FORM

Medillume III®

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HOW TO FILE A CLAIM

TO ENSURE PROMPT PROCESSING OF YOUR CLAIM, PLEASE PROVIDE THE FOLLOWING INFORMATION.

1. **Complete the EMPLOYEE INFORMATION section of this form.**
2. **Complete the HEALTHCARE EXPENSES section of this form.**

   IF NO OTHER COVERAGE IS AVAILABLE: If the expenses is for a charge not covered under any plan or other source of benefits, i.e. dental or vision expenses, you do not need to submit an explanation of benefits from the other plan. You must complete item 1 of the Healthcare Expenses section below.

   IF PAYMENT IS REJECTED BY ANOTHER PLAN, OR IF PARTIAL PAYMENT IS MADE BY ANOTHER PLAN OR ANY OTHER SOURCE: If you are requesting reimbursement for expenses which were rejected under any plan or other source of benefits, you MUST attach a copy of the explanation of benefits from which shows that the claim was rejected (with the reason for rejection) and/or whether partial payment was made. You must check item 2 of the Healthcare Expenses section of the form.

   IF PAYMENT IS REJECTED BY AN HMO PLAN: If you or your dependents are covered under a Health Maintenance Organization (HMO) plan, and that plan will not provide benefits for your expenses, you MUST attach a copy of the HMO description which lists eligible and ineligible expenses.
3. **The EMPLOYEE CERTIFICATION must be signed.**
4. **For each expense submitted, make sure you have attached either an itemized bill or a statement from the provider of service which shows the type of expense incurred, the dollar amount, and the date it was incurred.**

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALITIES.

EMPLOYEE INFORMATION

EMPLOYER NAME		ACCOUNT NUMBER
EMPLOYEE NAME	**SOCIAL SECURITY NO.**	**HOME PHONE NO:**

MAILING ADDRESS

STREET **CITY** **STATE** **ZIP CODE**

HEALTHCARE EXPENSES

For each healthcare expense for which you are requesting reimbursement, please complete the following:

Claimant Name	Provider of Service	Date of Service	Total Charge	Amount Paid by Other Sources	Amount to be Reimbursed
			Total Requested		

I certify that I do not have any coverage for the following benefits:

1. (Check if applicable): Medical _____ Dental _____ Vision _____ Hearing _____
   (If your claim is for one of these benefits, and you have certified that you do not have such coverage from any source, you do not need to attach an explanation of benefits from any carrier)

2. (Check if applicable): _____
   I certify that I have other coverage for the claim(s) being submitted, and I am attaching an explanation of benefits from my employer's plan and/or my spouse's employer's plan and/or any other source which shows that the claim was rejected (with the reason for the rejection) and/or partial payment was made.

EMPLOYEE CERTIFICATION

By signing below I certify that the charges attached for reimbursement are eligible medical expenses under the Internal Revenue Code; that they were incurred by myself or a dependent of mine for which I have/will claim an exemption on my income tax returns for the period in which the claim was incurred; that I have not been/will not be reimbursed by any entity for these charges; and that I will not claim these expenses as medical deductions on my income tax return.

_____ _____
Employee Signature Date

FOR EACH EXPENSE SUBMITTED, MAKE SURE YOU HAVE ATTACHED EITHER AN ITEMIZED BILL OR A STATEMENT FROM THE PROVIDER OF SERVICE WHICH SHOWS THE TYPE OF EXPENSE INCURRED, THE DOLLAR AMOUNT, AND THE DATE IT WAS INCURRED.