Health Care Expense Reimbursement Form

Employer Company Name: _____

Employee Name: _____ SS#: _____

Address: _____ City/State:_____ Zip: _____

Home phone or Email where you can be reached: _____

Please include documentation in the order you have it listed below and fill in totals for each available account with dates of service, description, and claim total, then sign and date below.

The documentation must include the following: Date(s) of Service, Type of expense (i.e. eye exam), amount of the expense incurred and the Name of the Service Provider.

NOTE: Cancelled Checks or credit card receipts/statements are not valid forms of documentation.

Date(s) of Service	Type of Service	Service Provider	Dollar Amount
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Claim Total: $ _____

I request reimbursement for the attached receipts under the Medical Reimbursement Plan. I certify that I or my eligible dependents have incurred these expenses. Furthermore, I declare that these expenses have not been reimbursed from any other source nor do I expect them to be. I certify that these expenses are for medical expenses as defined by Section 213 of the Internal Revenue Code.

Signature: X_____ Date: _____

Reminders:

- Provide proper documentation for all expenses submitted.
- Multiple expenses may be included on one form. If more space is needed, attach additional forms.
- Minimum payment amount is $10.00

Fax is the preferred means of claims submission. You may also email or mail this form (with your documentation) to:

Cafeteria Plan Company
PO Box 3684
Corrales, NM 87048
Phone: 505-822-9300
fax: 505-247-0568 or 1-866-207-3916
email: kkoss@rsabq.com