MEDICAL EXPENSE REIMBURSEMENT PLAN

REIMBURSEMENT REQUEST FORM

Employer	Plan #	Daytime Phone#	
Employee's Last Name	First Name	Employee's SS#	
Employee's Address (Street)	City	State	Zip
Expenses Incurred By:		Relationship to Employee:	

____ **CHECK HERE IF NEW MAILING ADDRESS**

ITEMS REQUIRED TO SUBMIT THIS FORM:

(1) Complete all pertinent information in the spaces provided, sign, date & return to Administrative Solutions, Inc..
(2) Attach an itemized Explanation of Benefits (EOB) from Insurance Carrier to support requested reimbursement(s).
(3) EOB MUST have date, expense description, amount of expense, and Patient Responsibility Amount clearly listed for approval.

DATE OF EXPENSE:	EXPENSE TYPE:	REQUESTED AMOUNT:
	TOTAL MEDICAL REQUESTED:	

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under the Plan with respect to such expenses; and that such expenses have not been reimbursed, or are not reimbursable, under any other benefit plan coverage. The undersigned fully understands that he or she alone is responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense. The Participant also acknowledges that the Participant alone is responsible for direct payment to the Service Provider of the expense(s) being requested for reimbursement and that the Employer, the Plan, or the Plan Administrator will not be liable for any lack of payment to the expense Service Provider should the Participant fail to submit payment to the expense Service Provider after receiving reimbursement from the Plan.

X________________________________
Signature

X__________________
Date

ADMINISTRATIVE SOLUTIONS, INC.

P. O. BOX 5809; FRESNO, CA 93755-5809
(559) 256-1320 / FAX (559) 256-1321

To be completed by Administrative Solutions	Date Claim Received:	Approved:	Denied:	Date Posted:	Posted By: