

# Reimbursement Request Form

**Employer Name**

**Employee Information**

**Check here if mailing address is new**

Last Name	First Name	Middle Initial
Home Address	City/ State	Zip Code
Home Phone	Work Phone	Date of Birth

**Items required in submitting 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) or receipt from Insurance Carrier/Provider to support requested reimbursement's.
- (3) EOB/RECEIPT MUST INCLUDE: Date of service, description of expense, cost of expense, amount patient responsible for clearly listed for approval.

**Please advise if we are to pay the member or provider (select one):**    **Member**    **Provider**

Date of Expense	Type of Expense	Expense Incurred By	Requested Amount
<b>Total Medical Requested</b>			

Provider's Name	Phone Number
Mailing Address	City/State/Zip

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 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 service provider should the participant fail to submit payment for the expense to the service provider after receiving reimbursement from the Plan.

Signature \_\_\_\_\_

Date \_\_\_\_\_



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