

MEDICAL EXPENSE REIMBURSEMENT CLAIM FORM

To request reimbursement, please complete this form and attach required documentation.

I certify that listed expenses have not been reimbursed by any other source, nor will they be reimbursed by any other source. In addition, I certify that these expenses were incurred for eligible members of my family or me.

Participant's Signature _____

Date _____

REQUIRED – CLAIM CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE

Employer Name: _____

Employee Name:
 LAST _____ FIRST _____ M.I. _____

SOCIAL SECURITY # _____ - _____ - _____ HOME TELEPHONE () _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PAY INSURED _____ PAY PROVIDER _____

(REQUIRED – COMPLETE ALL SECTIONS)

In order to receive reimbursement, copies of supporting documentation must be attached. If you selected the Pay Provider option, you must include the itemized bill from the provider listing exact dates of service (balance forward statements are not acceptable), services performed, charges, provider name, address and TIN. Also, you must submit an Explanation of Benefits (EOB) from your insurance company listing service dates, services performed and charges. Be sure it includes deductible, coinsurance and other patient responsibility amount messages. Please retain a copy of this claim form and supporting documentation for your records as we are unable to return original documents to you.

SERVICE DATE	DESCRIPTION	CLAIM TYPE	AMOUNT
			\$
			\$
			\$
			\$
			\$
			\$
			\$

Please submit the completed, signed form to the address below:



SIGNIFICA BENEFIT SERVICES, INC.
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