EMPLOYER FUNDED HEALTH REIMBURSEMENT FORM

Please type or print all information.

Employee Name: _____

Last 4 digits of Social Security Number: _____

MEDICAL EXPENSES

- Only employees participating in the plan can submit a reimbursement form.
- Reimbursements may be reimbursed from the plan at any time during the plan year.
- Documentation for each request will need to show date of service, description of service provided and charge for service as well as the providers name and address.
- For expenses that apply to your deductible or co inusrance please submit a copy of the Explanation of Benefits (EOB) from your insurance carrier
- Submit your reimbursement form and documentation to your employer.

Date of service	Provider name or name of store	Amount