



PA State System of Higher Education | Benefits, Hughes Hall | 2986 North Second Street | Harrisburg, PA 17110-1201 | Fax #717-720-4162 | www.passhe.edu

REIMBURSEMENT FORM FOR MEDICAL REIMBURSEMENT ACCOUNT

INSTRUCTIONS

- Attach explanation of benefits (EOB) from the insurance carrier or co-pay receipts
- If you are submitting an itemized bill only, indicate why this bill has not been paid by your insurance plan
- Itemized bills should include the following: provider name and address, patient name, itemized charges, date(s) of service, and type(s) of service
- Indicate item's purpose i.e. pain reliever, allergy medication, antacid, etc. on over-the-counter receipts with vague product description
- Cancelled checks, non-itemized receipts, and balance due bills are not acceptable proof of expenses
- Mail or fax completed form along with appropriate documentation to address or fax number at top of this form
- All spending account funds are paid directly to the employee through bi-weekly paychecks or direct deposit
- Any leftover funds from your prior calendar year's contribution will be used to reimburse claims that are incurred in January and February of the following year

EMPLOYEE INFORMATION

NAME (Last, First, MI)	Employee ID Number	University
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Employment Status: Active Leave without Pay Terminated

HEALTH CARE EXPENSES

Please indicate if you have the following types of coverage:

Dental Coverage Yes No Medical Coverage Yes No Vision Coverage Yes No

If yes, provide an explanation of benefits (EOB) or co-payment receipt.

Patient Name	Provider (i.e. Doctor Name/ Pharmacy Name)	Date(s) of Service	Types of Services Please check the appropriate box below for each expense(s) MD=medical RX=prescription VS =vision DN=dental HR=hearing OTC=over-the-counter	Amount to be Reimbursed
			MD <input type="checkbox"/> RX <input type="checkbox"/> VS <input type="checkbox"/> DN <input type="checkbox"/> HR <input type="checkbox"/> OTC <input type="checkbox"/>	
			MD <input type="checkbox"/> RX <input type="checkbox"/> VS <input type="checkbox"/> DN <input type="checkbox"/> HR <input type="checkbox"/> OTC <input type="checkbox"/>	
			MD <input type="checkbox"/> RX <input type="checkbox"/> VS <input type="checkbox"/> DN <input type="checkbox"/> HR <input type="checkbox"/> OTC <input type="checkbox"/>	
			MD <input type="checkbox"/> RX <input type="checkbox"/> VS <input type="checkbox"/> DN <input type="checkbox"/> HR <input type="checkbox"/> OTC <input type="checkbox"/>	

(For OC Use Only) Paydate Reimbursed

Total Reimbursement Request \$

CERTIFICATION

I certify that the expenses for which I am requesting reimbursement meet all of the following conditions listed below:

- They were incurred for services or supplies by me or my eligible dependents under the plan.
- They were for services or supplies furnished on or after the effective date of my employee reimbursement account.
- I have not been reimbursed for these expenses in any other way.

I understand that reimbursement of these expenses should be requested and made only after I have collected all benefit payments available from all plans under which my eligible dependents and I are covered. I further certify that I have not deducted or will not deduct on my individual income tax return any of the expenses reimbursed through my Medical Reimbursement account. I understand that reimbursement will be made in accordance with the provisions of the plan. I accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting, and liability.

Employee Signature	Date
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