

# Medical Reimbursement Claim Form

Employee /Dependent Name \_\_\_\_\_

Date Submitted to Employer \_\_\_\_\_

**Please attach your EOBs or receipts in order to be reimbursed for your qualifying medical expenses.**

Date of Treatment	Provider Name	Amount
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I certify that I have not been compensated by insurance or otherwise for the above expenses.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_