BOON-CHAPMAN

SECTION 125 FLEX

HEALTH CARE REIMBURSEMENT REQUEST FORM

Mail or Fax claim forms to:
Boon-Chapman
P.O. Box 9201
Austin, TX 78766
(800) 252-9653 Phone
(512) 459-1552Fax

A. INSTRUCTIONS

- COMPLETE ALL SECTIONS (B,C, AND D) FOR CHARGES TO BE CONSIDERED FOR REIMBURSEMENT.
- IF EXPENSE IS COVERED BY INSURANCE, SUBMIT TO APPROPRIATE CARRIER.
- 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 & ADDRESS * PATIENT NAME * ITEMIZED CHARGES * DATE OF SERVICE * TYPE OF SERVICE
- CANCELLED CHECKS, NON-ITEMIZED RECEIPTS AND BALANCE DUES ARE **NOT ACCEPTABLE** PROOF OF EXPENSES.

B. EMPLOYEE INFORMATION

EMPLOYEE SOCIAL SECURITY #	COMPANY NAME	NEW ADDRESS (**CIRCLE ONE**) YES NO	**PLAN YEAR**

LAST NAME	FIRST NAME	EMAIL ADDRESS

ADDRESS	CITY	STATE	ZIP CODE

C. HEALTH CARE EXPENSES

PLEASE INDICATE IF YOU HAVE THE FOLLOWING TYPES OF COVERAGE: (**CIRCLE ONE**)
DENTAL COVERAGE? YES NO
MEDICAL COVERAGE? YES NO
VISION COVERAGE? YES NO

***IF YES, PLEASE BE SURE TO PROVIDE AN EXPLANATION OF BENEFITS (EOB) OR CO-PAYMENT RECEIPT.**

PATIENT NAME	RELATIONSHIP	TYPE OF SERVICE PROVIDED	DATE OF SERVICE	REIMBURSEMENT REQUEST AMOUNT

D. CERTIFICATION

I CERTIFY THAT THE EXPENSES FOR WHICH I AM REQUESTING REIMBURSEMENT MEET ALL OF THE FOLLOWING CONDITIONS:

- 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 spending 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 Health Care Spending 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 *(REQUIRED)*	DATE