

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) 459-1552 Fax

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
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