MEDICAL REIMBURSEMENT REQUEST FORM

Name:	SS#:	Employer Name:	
Address:	City:	State:	_ Zip:
Home Phone #:	Work Phone #:		

INSTRUCTIONS: Complete the information below for medical expenses incurred by you, your spouse or other eligible dependents, for which you request reimbursement under the Medical Reimbursement Plan. <u>You must provide receipts or other evidence from the provider that the expenses were incurred (canceled checks will not be accepted)</u>. If this form is incomplete, it will be returned to you. Print or type the information requested, date and sign the form, then send this form along with your supporting documentation.

	EXAMPLE	EXPENSE #1	EXPENSE #2	EXPENSE#3	EXPENSE #4
Date(s) Medical Service Actually Provided	10/7/01				
Name of Person Receiving Medical Service/Relation You	Fred Jones ☑ Self □ Spouse □ Dependent	☐ Self☐ Spouse☐ Dependent	□ Self□ Spouse□ Dependent	□ Self□ Spouse□ Dependent	□ Self□ Spouse□ Dependent
Type of Service	Dental				
Total Expense	\$100.00	\$	\$	\$	\$
Amount Previously Reimbursed, or Paid/Payable Under Another Plan	\$0.00	\$	\$	\$	\$
Reimbursement Amount Requested	\$100.00	\$	\$	\$	\$

Total Amount Claimed: \$

To the best of my knowledge and belief, my statements in this Medical Reimbursement Request Form are complete and true. I certify that the services described above were received on the dates indicated, that the expenses qualify as valid medical services under the Plan, and that I have not been reimbursed previously under the Plan or any other health plan, nor do I expect any of these expenses to be reimbursable elsewhere. If the reimbursement is requested for prescribed drugs, I certify that such drugs are not prescribed for cosmetic purposes (hair growth, weight loss, etc.). I understand that these expenses may not be used to claim any federal income tax deduction or credit. I also acknowledge that should the actual expenses claimed be less than the amount available, such balance shall remain with the employer at the end of the Plan Year.

Employee Signature

Date

Email Address

RETURN THIS FORM ALONG WITH SUPPORTING DOCUMENTATION TO:



NATIONAL PLAN ADMINISTRATORS, INC. P.O. BOX 161630 AUSTIN, TX 78716 PHONE: (512) 327-6481 or (800) 880-2776 FAX: (512) 275-9396 or (800) 982-8140 WEB ADDRESS: www.natlplan.com EMAIL: 125@natlplan.com

QUALIFYING MEDICAL EXPENSES

The Medical Reimbursement Plan Document contains the rules governing what expenses are or are not reimbursable. Below are some examples to give you a general idea. Please contact National Plan Administrators, Inc. if you have any questions about whether a particular expense is reimbursable or not.

Examples of expenses for which you may be able to receive reimbursement include:

Over the Counter medications.	Prenatal Vitamins for pregnancy only.		
Deductibles and co-payments for medical, prescription drug, vision and/or dental expenses.	Hearing exams, hearing aids and batteries.		
Chiropractic expenses.	Individual psychotherapy.		
Eye exams, eyeglasses, contact lenses and other	Orthodontia monthly and down payments.		
vision expenses.	Acupuncture with letter of medical necessity.		

Examples of expenses for which you <u>cannot</u> be reimbursed include:

Vitamins and/or Supplements for general health Purposes.

Cosmetic surgery or other similar procedures or drug, which is directed at improving the patient's appearance and does not meaningfully, promote the proper function of the body to prevent or treat illness or disease.

Health club dues.

Services occurring prior to your plan year.

Custodial care.

Weight management related expenses unless letter of medical necessity from doctor.

Herbal remedies or drugs.

Teeth Bleaching/ Whitening or Vaneers.

CLAIM SUBMISSION PROCEDURES

According to the Internal Revenue Code Section 125, the Unreimbursed Medical and Dependent Care Flexible Spending Accounts (FSAs) may reimburse an expense if the participant provides

- A written statement, receipt or bill from an independent third party stating the expense(s) has been incurred,
- The amount of such expenses(s)
- The participant must also sign a statement that the medical/dental expense has not been reimbursed or is not reimbursable under any other health plan coverage.

Procedures for submitting claims that will help to ensure prompt and efficient processing:

- 1. ALL receipts submitted for Medical Expense Reimbursement expenses must include the following information:
 - Date of service,
 - Description and breakdown of all charges or services,
 - Prescription drug name,
 - Name of the person for whom the service was provided,
 - Provider's name and address,
 - Total amount of payment for which you are seeking reimbursement.
 - An Explanation of Benefits (EOB) from your insurance company, if applicable.
- 2. When filing orthodontic claims for the first time, NPA must have a copy of the Orthodontic Contract including the down/initial payment, schedule of payments, when banding will occur and the duration of the treatment. Thereafter, simply submit a claim form with the receipts and indicate that it is an orthodontic treatment expense. Claims can only be reimbursed for payment s made according to the orthodontic contract payment schedule.
- 3. Please be sure to retain copies of all items submitted to NPA for reimbursement.

