MEDICAL CLAIM FORM

Benefit Tax Link
122 Parish Drive
Wayne, NJ 07470
Www.benefittaxlink.com

Employer Name:_____

Employee Name:_____ _____ SS#: X X X - X X -_____
Last First Last 4 Digits Only

New Address : _____

Email Address: _____

Date of Service	Service Provided	Reimbursement Amount
	Total Reimbursable Expense	

Instructions:

1. Complete the top portion of the form.
2. List the eligible expenses:
   - *Date of Service:* The date the service was provided. Not the date it was billed.
   - *Service Provided*: Provide a brief description of the service received.
   - *Reimbursement Amount:* Enter the amount requested for reimbursement.
   (NOTE: if you have a Health Care Explanation of Benefits to attach, enter the difference between the total expense and the amount paid).
3. Sign and date your form.
4. Attach the required documentation:
   - for expenses which must be submitted to an insurance company or health care plan, attach a copy of the Explanation of Benefits (EOB) form received from your insurance company.
   - for eligible medical expenses not covered by a health care plan, attach a statement of expense showing the type of service, the incurred date and the amount of expense. For example, a physician's bill or pharmacist's prescription label or itemized receipt.
   Cancelled checks are not acceptable documentation.
5. Send completed form and attached documentation to Benefit Tax Link.
   For Prompt Service Fax to: 973-694-2913 or email: claims@benefittaxlink.com

I certify that the expenses listed above have been incurred by me and/or my dependent(s) and qualify for reimbursement, and that these expenses will not be claimed as a deduction on my personal income tax return. In addition the expenses listed above have not been reimbursed and are not reimbursable under any other health plan.

_____ _____
Your Signature Date