OPEC Funding Plan Claim Form

Employer Name	**Send This Completed Form To:** Ohio Public Entity Consortium P.O. Box 1135 Dublin, Ohio 43017 Phone: 800-989-9095 Fax: 614-873-2916
Employee Name	

Employee Address (Number, Street, City, State, Zip)

Employee Social No. _____ Employee Date of Birth _____ Employee Phone No. _____

I request reimbursement from the funds available in my Funding Plan. The services are qualified under the Plan and itemized below with my **Explanation of Benefits** from the Health Plan.

This section only required if information is not on EOB, Bill or Receipt

Patient Name	Relationship	Dates of Services	Descriptions of Services	$ Expense

I certify that I have not requested reimbursement under this Plan or from any other source for the above expenses. I understand that I cannot claim expenses reimbursed under this Plan on my personal income tax return. I agree to reimburse the company for any liability that may incur for failure to withhold income tax or Social Security tax because of a non-qualifying reimbursement paid to me as a result of incorrect information provided by me.

I acknowledge that the expense(s) has (have) been incurred as substantiated by the attached documentation and that they have not been, or will be, reimbursed by any other health Plan or other program.

Employee Signature _____ Date _____

<u>Major Medical Claims:</u> You must file with your primary insurance carrier and then submit your Explanation of Benefits (EOB).
<u>Office Visit Co-Pays:</u> You can submit your EOB or itemized Doctor's receipt showing your co-pay has been paid.