Medical Reimbursement Claim Form

Employee Name:	**Social Security #:**	
Street Address:		
City:	**State:**	**Zip:**
Home Phone:	**Business Phone #:**	
Employer Name:		

Instructions: For all reimbursable expenses, copies of all bills and receipts must be attached to the claim form. If possible, attach copies of other insurance carriers explanation of benefits to establish amounts not covered under the medical/dental plans. Electronic Checks, Canceled Checks, and Credit Card Receipts are NOT acceptable receipts. All receipts must have the following information on them before we can reimburse the claim:

- **Who rendered the service**
- **Date expense was incurred (not paid)**
- **Detailed description of services rendered**

Date of Expense	Description of Expense	Amount Paid

Employee Certification

I certify that all items requested comply with the Health Reimbursement Account Program and such items have not and will not be covered under any other plan or program of any other employer or other person. I further certify that such items will not be deducted or taken as tax credits on my personal federal income tax returns for any year. The Plan Administrator does not accept responsibility for direct payment to any individuals other than the employee.

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Employee Signature **Date**

4318 Woodcock Drive #130 * San Antonio, Texas 78228 * V (210) 738-1414 * F (210) 738-1341
paiget@ebsincorporated.com