Health Care Expense Reimbursement Form

EMPLOYER NAME: ____

Employee Name: ____________________________________ SS#: ____________________

Address: ___________________________ City/State: ____________________ Zip: __________

Phone number where you can be reached: ________________ Email: ________________________

<u>This form should be copied for future use</u>

Please staple documentation in the order you have it listed below and fill in totals for each available account with dates of service, description, and claim total, then sign and date below. *The documentation must include the following:* Date(s) of Service, Type of expense (i.e. eye exam), amount of the expense incurred and the Name of the Service Provider.

NOTE: Cancelled Checks or credit card receipts/statements are not valid forms of documentation.

Date(s) of Service	Type of Service	Service Provider	Dollar Amount
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Claim Total: $ ____________

I request reimbursement for the attached receipts under the Medical Reimbursement Plan. I certify that I or my eligible dependents have incurred these expenses. Furthermore, I declare that these expenses have not been reimbursed from any other source nor do I expect them to be. I certify that these expenses are for medical expenses as defined by Section 213 of the Internal Revenue Code.

Signature: X ________________________________ Date: ________________

Reminders:

- Provide proper documentation for all expenses submitted.
- Multiple expenses may be included on one form. If more space is needed, attach additional forms.
- Minimum check amount is $10.00

Fax or Mail this form (with your receipts) to:

The Cafeteria Plan Company
500 4th Street, NW Suite 301
Albuquerque, NM 87102 phone: 505-822-9300 fax: 505-247-0568