


MEDICAL REIMBURSEMENT REQUEST

 BENEFIT SERVICES™ <small>A DIVISION OF MEDICAL MUTUAL SERVICES, LLC</small>	SUBMIT CLAIMS TO :	BENEFIT SERVICES
	phone (330)666-0337 fax (330)666-2845	P.O. BOX 4430 AKRON, OHIO 44321 toll free 800-367-3762 ext 14535

****EMPLOYEE INSTRUCTIONS****

- 1. COMPLETE PARTS A & B IN FULL**
- 2. ATTACH COPY OF EXPLANATION OF BENEFITS (EOB's) FOR DEDUCTIBLE AND COINSURANCE REIMBURSEMENT REQUESTS**
- 3. ATTACH ITEMIZED BILLS FOR EXPENSES NOT COVERED BY MEDICAL/DENTAL INSURANCE**
- 4. ALL REQUESTS FOR OVER-THE-COUNTER (OTC) EXPENSES MUST BE ACCOMPANIED BY A RECEIPT OF PURCHASE SHOWING THE DATE PURCHASED, THE AMOUNT PAID AND THE NAME OF THE PRODUCT**

PART A FAILURE TO ANSWER ALL QUESTIONS MAY CAUSE DELAY IN PAYMENT

ADDRESS CHANGE ? (PLEASE CIRCLE) YES NO

EMPLOYEE NAME (FIRST, MIDDLE, LAST)	STREET ADDRESS	CITY	STATE	ZIP CODE
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DATE OF BIRTH	EMPLOYER	SOCIAL SECURITY NUMBER
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DEPENDENT NAMES	SEX (PLEASE CIRCLE)	RELATIONSHIP TO EMPLOYEE
1	MALE FEMALE	
2	MALE FEMALE	
3	MALE FEMALE	
4	MALE FEMALE	
5	MALE FEMALE	

PART B REIMBURSEMENT REQUEST

1. DEDUCTIBLE & COINSURANCE EXPENSES	\$ _____
2. EXPENSES NOT COVERED BY INSURANCE	\$ _____
3. OVER-THE-COUNTER(OTC) EXPENSES	\$ _____
TOTAL REIMBURSEMENT REQUEST	\$ _____

YOUR PLAN HAS ADOPTED A 2 1/2 MONTH GRACE PERIOD. YOU MUST INDICATE FROM WHICH PLAN YEAR YOU WISH TO BE REIMBURSED, OTHERWISE, FUNDS WILL BE REIMBURSED FROM THE PRIOR YEAR

School Year 2008/2009 _____ School Year 2009/2010 _____

I HEREBY REQUEST THAT THE EXPENSES SHOWN ABOVE BE CONSIDERED FOR PAYMENT. I CERTIFY THAT THESE EXPENSES ARE NOT ELIGIBLE FOR PAYMENT UNDER ANY INSURANCE PLAN. I UNDERSTAND THAT ANY EXPENSES REIMBURSED CANNOT BE USED FOR TAX DEDUCTIONS ON MY FEDERAL INCOME TAX RETURN.

_____ EMPLOYEE SIGNATURE	____/____/____ DATE
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