# FLEXIBLE BENEFITS
# UNREIMBURSED MEDICAL EXPENSE
# CLAIM FORM

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A copy of the provider's itemized bill, your explanation of benefits and a copy of the paid receipt **MUST** be attached.

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Employee Name ____________________ Banner ID ____________________

Mailing Address ____________________

Provider of Service ____________________ Date of Service ____________________

Total of Bill ____________________ Total Reimbursement Requested ____________________

| Dependent Name | Relationship | Age | Date of Service | Amount |
|---|---|---|---|---|
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**I certify that the requested reimbursement amount has not been paid by HCH Administration or by any other plan.**

Employee's Signature ____________________ Date ____________________