



**FLEXIBLE BENEFITS
UNREIMBURSED MEDICAL EXPENSE
CLAIM FORM**

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

Employee Name

SSN(Last 4)

Mailing Address

Provider of Service

Date of Service

Total of Bill

Total Reimbursement Requested

Dependent Name	Relationship	Age	Date of Service	Amount

I certify that the requested reimbursement amount has not been paid by NMPSIA or by any other plan.

Employee's Signature

Date