NEW MEXICO TECH
SCIENCE • ENGINEERING • RESEARCH UNIVERSITY

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 _____

Jan 2027