



# MEDICAL EXPENSE REIMBURSEMENT REQUEST

(USE THIS FORM TO SUBMIT CLAIMS BY FAX OR MAIL)

(To send scanned claims go to: <https://secure.abpmtpa.com/flexupload>)

FAX: 406-523-3149 or TOLL FREE FAX: 877-424-3539

PHONE: 406-721-2222 or TOLL FREE PHONE: 877-424-3570

Please visit [www.abpmtpa.com](http://www.abpmtpa.com) for additional forms.

### Comment Box

Return FAX # \_\_\_\_\_

Return Phone # \_\_\_\_\_

PAGES: \_\_\_\_\_ including this cover sheet

**Attention To:**

Please use black or dark blue ink. Do not use highlighter, red ink or gel pens. Do not include day care expenses on this form.

Company: (Print) \_\_\_\_\_  
**(Required)**

Employee Name: (Print) \_\_\_\_\_ SSN: \_\_\_\_\_  
**(Required) (Required)**

List eligible medical, dental or vision services and expenses for you and your family that you have not already claimed through flex. Only list the amount of the expense you have to pay after insurance pays its share. Insurance premiums, deducted by your employer, are NOT eligible.

### **PLEASE SEE REVERSE FOR FILLING CLAIM INSTRUCTIONS**

<b><u>Types of Expenses</u></b>	<b><u>Dates Incurred</u></b>	<b><u>Total Out-of-Pocket Expense</u></b>
<b>Total Medical Reimbursement Requested</b>	From _____ To _____	\$ _____
<b>Total Prescription Reimbursement Requested</b>	From _____ To _____	\$ _____
<b>Total Vision Reimbursement Requested</b>	From _____ To _____	\$ _____
<b>Total Dental / Ortho. Reimbursement Requested</b>	From _____ To _____	\$ _____
<b>Total OTC Drugs Reimbursement Requested</b> (Over The Counter)	From _____ To _____	\$ _____
<b><u>Total Reimbursement Requested</u></b>		<b>\$ _____</b>

YOU MUST SUBMIT INDEPENDENT, 3RD-PARTY DOCUMENTATION OF YOUR EXPENSES WITH THIS CLAIM FORM. IF ANY OF THESE EXPENSES WERE COVERED BY INSURANCE, ATTACH A COPY OF THE "EXPLANATION OF BENEFITS" FROM YOUR INSURANCE COMPANY AS DOCUMENTATION. FOR EXPENSES NOT COVERED BY INSURANCE, SEND A COPY OF A BILL OR INVOICE IDENTIFYING THE SERVICE, SERVICE DATE, TOTAL CHARGES AND ANY DISCOUNTS. IF THE REQUIRED DOCUMENTATION IS NOT ATTACHED, YOUR REIMBURSEMENT WILL BE DELAYED.

I certify that these statements are true and that the claimed expenses were incurred to diagnose, cure, treat, mitigate, and/or prevent a disease and cover only myself, my tax dependents, and/or spouse (if filing taxes jointly). I understand that items purchased merely to promote general health are not reimbursable. I further understand that expenses reimbursed by FLEX may not be claimed on my individual tax return at the end of the year.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**(Required)**

Check here if your address has changed. Please list to the right.

New Address: \_\_\_\_\_

## FILING A CLAIM


Please read these important reminders for quick and efficient reimbursement:

- Please make sure to fill out your form completely (employer, ss#, your name).
- Combine all like reimbursement requests. For example, If you are submitting several prescription receipts for reimbursement, enter the range of dates over which the purchases were made and the total of all the receipts on the prescription line:

Total Prescription Reimbursement Requested                      From: 07/01/05 To: 07/31/05    \$243.58

- Service dates must be within the plan year to be eligible expenses. If your employment terminates during the plan year, service dates must be within the plan year **and** while you were an active participant in the plan (ie: eligible and making contributions).
- If your claim is covered by insurance, an explanation of benefits must accompany the claim form, unless your bill or receipt is clearly identified as a co-pay amount. Bills from providers that estimate insurance coverage will not be reimbursed.
- If the reimbursement requested is not covered by insurance, an itemized bill or receipt is adequate documentation of the expense, as long as there is no reference to insurance coverage on the bill or receipt.
- If have questions about filing claims, please call Allegiance at the number listed on the front of this form.

## FLEX CLAIMS CHECKLIST

 <b>ALLEGIANCE</b> <small>BENEFIT PLAN MANAGEMENT, INC.</small>	<u>Medical Claim Form</u>	<u>Co-Pay Receipt if even dollar amount Ex. \$10, \$15</u>	<u>Itemized Cash Register Receipt</u>	<u>Itemized Statement</u>	<u>Explanation Of Benefits If not even \$ amount</u>
<b><i>Insured Expenses</i></b>					
<u>Vision</u>	X	X			X
<u>Dental</u>	X	X			X
<u>Medical</u>	X	X			X
<u>Prescriptions</u>	X	X			X
<b><i>Uninsured Expenses</i></b>					
<u>Vision</u>	X			X	
<u>Dental</u>	X			X	
<u>Medical</u>	X			X	
<u>Prescriptions</u>	X		X	X	
<u>Over the Counter Drugs</u>	X		X		