ADMINISTRATION RESOURCES, INC.
EMPLOYEE BENEFIT ADMINISTRATION

MEDICAL DEDUCTIBLE REIMBURSEMENT CLAIM FORM

EMPLOYEE INFORMATION– PLEASE PRINT NEATLY

EMPLOYER NAME				
EMPLOYEE NAME			SOCIAL SECURITY NUMBER	
EMPLOYEE'S ADDRESS STREET		CITY	STATE	ZIP CODE

DATES OF SERVICE FROM TO	NAME OF PROVIDER	PERSON RECEIVING SERVICE	AMOUNT OF BILL	DESCRIPTION OF SERVICES RECEIVED
1.				
2.				
3.				
4.				
5.				
6.				
7.				
	TOTAL BILLS ➔			

SUBMIT THE FOLLOWING WITH THIS FORM:

ORIGINAL BLUE CROSS/BLUE SHIELD "EXPLANATION OF BENEFITS" (PAID CLAIM STATEMENT)
AND
THE BILLING STATEMENT FROM THE HEALTH PROVIDER FOR THOSE SERVICES

EMPLOYEE'S STATEMENT AND AUTHORIZATION TO RELEASE INFORMATION

I certify that information furnished by me in support of this claim is true and correct. I understand that such information is subject to verification and the audit procedures of the Company. I also understand that claims without proper documentation will not be reimbursed.

I also certify that the expenses 1) have been incurred on or during the dates indicated and have been or will be paid; 2) are eligible for reimbursement under the plan as described in the Plan Description; 3) have not previously been reimbursed by and will not be reimbursed again by this or any other plan or insurance policy; and 4) will not be deducted or claimed for credit for income tax purposes.

Signature_____ Date Signed _____

Send the completed form with EOB and Billing Statement to ARI

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