

Reimbursement Request for Medical Expense

FlexChoice: A flexible benefits plan

Group name _____

Employee name _____ Social Security number _____

If recent change in address, please update.

Address _____
street city state ZIP

For medical or dental expenses that were submitted to an insurance plan, but were not covered by the plan, attach copies of the *Explanation of Benefits* you received. These are necessary to show the amounts not covered by the insurer.

For all expenses not eligible for insurance reimbursement, verifying documentation must accompany this request. It must indicate date of service, which family member received the service, provider name, description of service, and amount requested to be reimbursed.

Medical expenses

Date of Service	Family Member Receiving Service	Provider Name	Description of Service	Requested Amount
Total				

Please see other side for helpful information on filing a reimbursement request.

I certify that all expenses requested above have been incurred and **have not been reimbursed (nor will be eligible for reimbursement) by any other insurance**. I understand that all medical expenses listed above may not be claimed as a deduction on my personal income tax return.

I fully understand and agree that, by signing this form, I assume responsibility for any liability which arises out of submission or payment of a request for reimbursement. I will solely be liable for any penalties or damages as a result of an inappropriate claim being filed.



MMA Insurance Company
 Post Office Box 483
 Goshen IN 46527
 Toll-free: (800) 348-7468
 Telephone: (574) 533-9511
 www.mma-online.org

 Employee's signature

 Date

Reimbursement request instructions

1. Complete the *Reimbursement Request* form and attach verifying documentation.
2. **Be sure you sign and date the form.**
3. Retain a copy for your records as those submitted documents will not be returned. **It is your responsibility to provide support for claims for IRS purposes.**
4. Mail or fax the completed *Reimbursement Request* and supporting documentation to MMA, Attn: FlexChoice, P.O. Box 483, Goshen, IN 46527; fax: (574) 537-6642.

Helpful information

Medical expenses

1. Expenses covered by other insurance should first be filed as a medical claim. Once you receive an *Explanation of Benefits* indicating an unreimbursed portion, please photocopy it and send the copy with your signed and dated *Reimbursement Request*.
2. Eligible verifying documentation includes photocopies of any of the following:
 - Explanation of Benefits, indicating unpaid portion
 - Original bill
 - Itemized bills from doctor, dentist, or other supplier of service
 - Paid receipt from provider

Eligible unreimbursed health care expenses include (but are not limited to) the following:

Acupuncture	Laboratory fees
Alcohol and drug rehabilitation expenses	Medical supplies
Ambulance	Nursing care
Anesthesiologist	Obstetrical expenses
Artificial limbs and teeth	Orthodontia expense
Birth control pills	Orthopedic shoes (when prescribed by doctor)
Braces (leg, back, etc., when prescribed by doctor)	Oxygen
Braille books and magazines	Physician fees
Care for a mentally handicapped child	Prescription drugs
Chiropractor	Psychiatric care
Coinsurance	Psychologist
Contact lenses and solution	Routine physical and other non-diagnostic services
Copayments	Special communications equipment for the deaf
Deductibles	Special education for the blind
Dental care and dentures	Surgery
Eyeglasses and eye exams	Therapy treatments (when prescribed by a doctor)
Hearing aids and batteries	Transportation expense relative to illness
Home health care	Tuition at special school for the handicapped
Hospital expenses	Wheelchair
Insulin and related supplies	X-rays

If you need a more complete listing, see your Human Resources Department for a copy of the IRS Publication 502.