REQUEST FOR REIMBURSEMENT FORM

Group Name: _____ Date: _____

Employee Name (Please Print): _____ Phone: _____

Address: _____

Please attach a fully itemized bill for services provided. Please attach a prescription label or prescription receipt which includes the name and address of the pharmacy, date prescription was filled, name of the medication, patient and amount paid for prescription services. A cash register receipt alone cannot be accepted because it does not contain the proper information.

MEDICAL, DENTAL, VISION, PRESCRIPTION, HRA and FLEX EXPENSES

Name of Patient	Date of Service	Pay Provider or Employee	Reimbursement Amount

Please sign and date the form below.

_____ _____

Signature Date

6307 – 84th Street PO Box 17 Caledonia, MI 49316
Phone (800) 466-4198 Fax (616) 891-9009