HealthNow Administrative Services

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UNREIMBURSED EXPENSES CLAIM FORM

Group Name: _____

Group Number: _____

Employee's Full Name:	Date of Birth:			Employee Identification Number:
	Mo.	Day	Year	

Street Address ☐ *Check if new address* City State Zip

List Unreimbursed Expenses

Attach bills, receipts, explanation of benefits from other carriers, cancelled checks or other supporting claim documentation.

Family Member	Age	Description of Expense	Name of Service Provider	Service Provider SS# or Tax ID	Date Incurred From To	Reimbursement Amount Requested
				Total		$_____

I certify that all expenses for which reimbursement is claimed were incurred (i.e., services were provided) during a period while I was covered under this plan and that such expenses have not been reimbursed, or are not reimbursable, under any other health plan coverage.

I understand that I am fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim.

Employee Signature _____ Date _____

Daytime Phone Number _____ Evening Phone Number _____