|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| MEMBER NAME: (print last name first) |  | |  | | | ACTIVE | RETIREE |
| HOME ADDRESS: Number & Street | Apt # | | | Contact Phone # | | | |
| CITY |  | STATE | | | ZIP | | |

I certify that the information given is correct and authorize release of any information necessary to process this claim.

**MEMBER**

**SIGN HERE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Valid **proof of** payment must be provided in order to be reimbursed. Please include copies of co-pay/prescription receipts, prescription printout from your pharmacy, DR/ER visit printout that shows payment(s) made, copy of bank/credit card statements or copy of cancelled check as proofs of payment. **Explanation of Benefits (EOB) from your insurance carrier is NOT acceptable as proof of payment.**

CLAIMS WILL ONLY BE PROCESSED FROM FEBRUARY 1, 2019 THROUGH FEBRUARY 28, 2019

**CLAIMS POSTMARKED AFTER FEBRUARY 28, 2019 WILL NOT BE CONSIDERED**

**REIMBURSEMENT MAXIMUM $300 PER MEMBER**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **DATE** | **EXPENSE** | **AMOUNT** |
| **1** |  |  |  |
| **2** |  |  |  |
| **3** |  |  |  |
| **4** |  |  |  |
| **5** |  |  |  |
| **6** |  |  |  |
| **7** |  |  |  |
| **8** |  |  |  |
| **9** |  |  |  |
| **10** |  |  |  |
| **11** |  |  |  |
| **12** |  |  |  |
|  |  | **TOTAL AMOUNT** |  |

**Use reverse side for added submissions**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **DATE** | **EXPENSE** | **AMOUNT** |
| **13** |  |  |  |
| **14** |  |  |  |
| **15** |  |  |  |
| **16** |  |  |  |
| **17** |  |  |  |
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| **26** |  |  |  |
| **27** |  |  |  |
| **28** |  |  |  |
| **29** |  |  |  |
| **30** |  |  |  |
|  |  | **TOTAL AMOUNT** |  |