



# MEDICAL EXPENSE REIMBURSEMENT REQUEST

(USE THIS FORM TO SUBMIT CLAIMS BY FAX OR MAIL)

(To send scanned claims go to: <https://secure.abpmtpa.com/flexupload>)

FAX: 406-523-3149 or TOLL FREE FAX: 877-424-3539

PHONE: 406-721-2222 or TOLL FREE PHONE: 877-424-3570

Please visit [www.abpmtpa.com](http://www.abpmtpa.com) for additional forms.

### Comment Box

Return FAX # \_\_\_\_\_

Return Phone # \_\_\_\_\_

PAGES: \_\_\_\_\_ including this cover sheet

Attention To: \_\_\_\_\_

Please use black or dark blue ink. Do not use highlighter, red ink or gel pens. Do not include day care expenses on this form.

Company: (Print) \_\_\_\_\_

(Required)

Employee Name: (Print) \_\_\_\_\_ SSN: \_\_\_\_\_

(Required)

(Required)

List eligible medical, dental or vision services and expenses for you and your family that you have not already claimed through flex. Only list the amount of the expense you have to pay after insurance pays its share. Insurance premiums, deducted by your employer, are NOT eligible.

### PLEASE SEE REVERSE FOR FILLING CLAIM INSTRUCTIONS

<u>Types of Expenses</u>	<u>Dates Incurred</u>	<u>Total Out-of-Pocket Expense</u>
Total Medical Reimbursement Requested	From _____ To _____	\$ _____
Total Prescription Reimbursement Requested	From _____ To _____	\$ _____
Total Vision Reimbursement Requested	From _____ To _____	\$ _____
Total Dental / Ortho. Reimbursement Requested	From _____ To _____	\$ _____
Total OTC Drugs Reimbursement Requested (Over The Counter)	From _____ To _____	\$ _____
<b><u>Total Reimbursement Requested</u></b>		<b>\$ _____</b>

YOU MUST SUBMIT INDEPENDENT, 3RD-PARTY DOCUMENTATION OF YOUR EXPENSES WITH THIS CLAIM FORM. IF ANY OF THESE EXPENSES WERE COVERED BY INSURANCE, ATTACH A COPY OF THE "EXPLANATION OF BENEFITS" FROM YOUR INSURANCE COMPANY AS DOCUMENTATION. FOR EXPENSES NOT COVERED BY INSURANCE, SEND A COPY OF A BILL OR INVOICE IDENTIFYING THE SERVICE, SERVICE DATE, TOTAL CHARGES AND ANY DISCOUNTS. IF THE REQUIRED DOCUMENTATION IS NOT ATTACHED, YOUR REIMBURSEMENT WILL BE DELAYED.

I certify that these statements are true and that the claimed expenses were incurred to diagnose, cure, treat, mitigate, and/or prevent a disease and cover only myself, my tax dependents, and/or spouse (if filing taxes jointly). I understand that items purchased merely to promote general health are not reimbursable. I further understand that expenses reimbursed by FLEX may not be claimed on my individual tax return at the end of the year.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Required)

Check here if your address has changed. Please list to the right. New Address: \_\_\_\_\_