

COLUMBUS STATE UNIVERSITY

Request for Medical Care
Expense Reimbursement
for calendar year 200__

Send or mail completed form to

Human Resources
Columbus State University
4225 University Ave
Columbus, GA 31907



SSN _____
Name _____
Address _____
Daytime Phone _____

Use this form only for:
*Expenses applied to your deductible.
*The unpaid balance of a health/dental claim.
*Eligible expenses not covered by any health/dental insurance.

You must attach copies of required documentation for each claimed expense to receive reimbursement.

*For expenses which must be submitted first to an insurance company or health care plan, attach a copy of the **Explanation of Benefits (EOB)** form you received from the insurance company. This includes expenses applied to your deductible. If additionally insured, provide all EOBs.

*For non-covered medical expenses (for example: eyeglasses, chiropractic care), attach a statement of expenses showing the service provided, the actual expense, and the amount paid.

Provider of Service	Person receiving service	Relationship to Employee	Birthdate	Date(s) of Service	Reimbursement

You should receive your reimbursement check in approximately 10-14 days.

Total reimbursement
Minimum of \$10.00

Certification:

I hereby certify that all expenses indicated above were incurred by me and/or my eligible dependents. I further certify that I have not Previously received reimbursement for these expenses from any group insurance plan or the Columbus State University Flexible Spending Account. I understand that any expenses reimbursed through the Flexible Spending Account cannot be claimed on my personal federal income tax return. Furthermore, I understand that I cannot be reimbursed for claims outside of my "period of coverage," that is, the portion of the year during which I am not enrolled in the Med-Flex program. Columbus State University does not assume any liability for ineligible expenses that are submitted for reimbursement from the Medical Spending Account. Eligible expenses are verified using IRS guidelines.

Employee Signature _____ Date _____

Approved for Reimbursement _____ Date _____

This form may be duplicated as needed. Additional forms are available in Human Resources.

