

HEALTH PLAN ALTERNATIVES AGENCY, INC.
P.O. BOX 884
WESTERVILLE, OHIO 43081
(800)898-8262 (614)890-8262

**REIMBURSEMENT REQUEST FORM
FOR SECTION 125 CAFETERIA PLAN**

(Please Print)

Participant s Name _____

Place Of Employment _____

Social Security Number _____

MEDICAL CARE EXPENSE (if additional space is needed please use back of form.)

Date of Service	Service Provider	Description of Service	Person receiving Service	Net Amount
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
Total medical expenses from reverse side				\$ _____

Total amount of medical expense \$ _____

CHILD CARE: If you are having reductions made for child care but are not receiving automatic reimbursements on your pay dates, you may also use this form for your child care reimbursement requests.

In order to process a request for reimbursement we must have a statement of services rendered along with proof of payment. Please attach an itemized bill showing date of service, patient's name, services rendered and payment for each expense listed above. A cancelled check along with the itemized bill is acceptable also.

I certify that I am claiming reimbursement for eligible expenses only and that these expenses have not been previously reimbursed under this or any other benefit plan. I certify that these expenses were incurred during an applicable plan year and that they were incurred for eligible plan participants. I understand these expenses will no longer qualify as tax deductions or credits.

Employee Signature: _____ **Date:** _____