PLATTE CANYON

Medical Insurance Deductible Claim Reimbursement Form

How To Prepare Your Claim Form (Plan Year is Jan. 1 thru Dec. 31. You have 30 days from date of service to submit your claim)

Step 1 Complete all requested employee information.
Step 2 Complete expense information. If the expense was incurred for an eligible dependent, indicate type of relationship in the box on the dependent name line.
Step 3 Print, sign and date the claim form and attach proof of expense (i.e. statements and Explanation of Benefits (EOBs) from medical plan). Proof of payment is not required.

IMPORTANT! **DO NOT** combine multiple expenses on a single line. List each expense separately. Always send the claim form followed by its supporting documentation. Retain a copy for your records. The District will reimburse up to $1,500.00 per person, but no more than $4,500.00 per family.

Employee Information:

Name: _____

Email: _____ Date: _____

Employee Information:

Date of Service (mm/dd/year)	Note: Please report **only one** expense per block. Combining multiple expenses to one block may result in a delayed reimbursement	Amount (dollars and cents)
	Name of Provider: _____ Dependent Name: _____ *(Only if not for employee)*	$
	Name of Provider: _____ Dependent Name: _____ *(Only if not for employee)*	$
	Name of Provider: _____ Dependent Name: _____ *(Only if not for employee)*	$
	Name of Provider: _____ Dependent Name: _____ *(Only if not for employee)*	$
	Name of Provider: _____ Dependent Name: _____ *(Only if not for employee)*	$
	Name of Provider: _____ Dependent Name: _____ *(Only if not for employee)*	$
	Name of Provider: _____ Dependent Name: _____ *(Only if not for employee)*	$
Submit Your Claim to the Assistant Manager for Approval (If you need additional information or have questions, please see the District Manager or Assistant Manager)	**Total Expenses**	$0

Certification

I certify that the expenses listed above qualify for reimbursement and have been incurred by me or by my eligible dependents. These expenses have not been reimbursed by my health care plan or any other health care plan, such as my spouse's. Additionally, these expenses are not being claimed as tax deductions under Section 213 of the IRS code. Statements or other proof of the expenses are attached.

Signature: _____ Date: _____

Plan Administrator: _____ Date: _____ Amount Approved: $ _____