ARCHDIOCESE OF ST. LOUIS FLEXIBLE BENEFIT REIMBURSEMENT HEALTH CARE CLAIM FORM

PLEASE READ THE GUIDELINES FOR ELIGIBLE REIMBURSEMENTS ON THE REVERSE SIDE

1. Employee Information: Complete all sections.

Employer Information	Parish/Agency Employer Name			
Employee Information ☐ Check box if new address.	Employee's Last Name	First Name	Initial	Employees Social Security No. - -
	Home Address			
	City	State	Zip	Daytime Phone Number

2. Health Care: An itemized statement is required including date of service, type of service, and total charge. Certain procedures and prescription medication is not reimbursable under the Archdiocese of St. Louis Health Reimbursement plan.

ALL PRESCRIPTION DRUG CLAIMS MUST INCLUDE DOCUMENTATION FROM THE PHARMACY THAT CLEARLY IDENTIFIES THE NAME OF THE MEDICATION IN ORDER TO RECEIVE REIMBURSEMENT FROM THE ARCHDIOCESE OF ST. LOUIS HEALTH REIMBURSEMENT PLAN.

Please check one of the following boxes:

☐ Charges attached are partially covered benefits under my health and/or dental insurance coverage. Enclosed is an Explanation of Benefits from my insurance. An Explanation of Benefits is required even if charges are applied to your deductible or out-of-pocket liability.

☐ Charges are **not** a covered benefit by any insurance plan for which the patient is enrolled.

☐ Charges attached are for reimbursement of my office visit or prescription drug co-pay due at the time of service. My insurance company does not provide an Explanation of Benefits for these services. Enclosed is an itemized receipt provided by the provider of service.

Date (s) Incurred	Name of Person Receiving Care	Description of Expense	Provider Name (i.e., clinic, doctor, hospital)	Total Expense	Amt. Paid by Insurance	Amount Remaining
			TOTAL AMOUNT OF MEDICAL EXPENSE	$	$	$

3. Employee Certification: Employee signature required.

I certify that the above information is correct. I understand any medical reimbursements I receive may not be included on my income tax return. I certify that I am requesting reimbursement of medical expenses, which will not be paid or reimbursed under any other plan. I certify that these expenses qualify for reimbursement under the Internal Revenue Code AND the Archdiocese of St. Louis Health Reimbursement Plan as outlined on the reverse side of this form and the Plan Document.

Employee's Signature	Date / / Mo. Day Year

Please mail or fax the completed claim form and appropriate statements to:

Tristar Benefit Administrators

P.O. Box 65887, West Des Moines, IA 50265-0887

(800) 456-4584

Fax (515) 224-7367

Shaded area completed by Tristar

Reference Number:_____ Date:_____