

SISTERS OF MERCY/MERCYHURST PREPARATORY SCHOOL
DEDUCTIBLE REIMBURSEMENT FORM

- Please complete this form and attach the Explanation of Benefits (EOB) from the insurance company.
- **IF THE EXPLANATION OF BENEFITS IS NOT INCLUDED, YOUR REQUEST FOR REIMBURSEMENT WILL BE DENIED.**
- Reimbursement will be issued directly to the Employee.
- Mail or Fax this form directly to Beneflex, 1030 State St, Suite 2, Erie, PA 16501 or Fax:(814) 461-6590
- Questions: (814) 453-3107

Social Security # _____ Daytime Phone # _____

Employee's Name _____

Complete Address _____

E-mail Address _____

DESCRIPTION OF EXPENSES AND REIMBURSEMENT AMOUNT REQUEST

Deductible Reimbursements for You & Your Family

Patient's Name	Relationship	Date of Service	Service Provider	Amount of Deductible

***TOTAL REQUEST FOR REIMBURSEMENT:** \$

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

- I certify that the expenses listed on this form are eligible for reimbursement pursuant to the provisions of the SISTERS OF MERCY/MERCYHURST PREP Medical Expense Reimbursement Plan.
- I certify that the deductible is not eligible for reimbursement by any other benefit plan, and that I will not include them as itemized deductions on my personal income tax returns.

Employee's Signature _____ Date _____

*Reimbursement will be issued to the employee.
The employee is responsible for provider payment.*