



RH Administrators, Inc.
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**MEDICAL EXPENSE REIMBURSEMENT PLAN
 (MERP)
 CLAIM FORM**

INSTRUCTIONS

1. Please complete all sections below.
2. If expense is covered by insurance, submit to appropriate carrier.
3. Attach **all pages** explanation of benefits (EOB) from the insurance carrier.

EMPLOYEE INFORMATION

Employee Social Security #		Company Name		New Address (circle one) Yes No	
Last Name			First Name		
Address			City	State	Zip Code
Daytime Phone			Email		

MERP EXPENSES

ALL PAGES OF YOUR EXPLANATION OF BENEFITS (EOB) MUST ACCOMPANY ALL REQUESTS FOR REIMBURSEMENT. Please attach a copy of the Medical Claim Form (HCFA) from the provider. If you are unable to obtain a Medical Claim Form, this form MUST be completed and signed by the provider.

Patient Name	Relationship of the patient to the Employee	Provider Name/Tax ID/NPI Number	Provider Mailing Address/Telephone Number	Patient Account Number
Dates of Service	Diagnosis Code(s)	CPT Code(s)	Charge Amount \$\$\$	Number of Units
Provider Signature: Assignment of Benefits to Provider:			Date:	
			Date:	
	Employee Signature: (Required)			

EMPLOYEE CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or my eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Medical Expense Reimbursement Plan. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return. I understand reimbursement will be made in accordance with the provisions of the plan. I accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting, and liability.

Employee Signature (Required)	Date
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