



# Payment Request

Employer: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date: \_\_\_\_\_

## IMPORTANT INFORMATION

### Health (Medical, Dental and Vision) and Flex Reimbursement:

You **must** attach an itemized statement or Explanation of Benefits (EOB) for each expense claimed. If the services for this expense is covered by any other insurance carrier or plan, you **must** attach the EOB from that carrier.

### Prescription Reimbursement

You **must** attach a prescription label that should include the pharmacy name and address, the date filled, the drug name, prescription number, quantity, price, and the patient's name.

### Dependent Care Reimbursement:

You **must** attach a Dependent Care Receipt including dates of care, provider name, address, tax identification number/social security number, dependents in care, and amount of expenses.

I certify the information contained within this claim for reimbursement is correct.

I understand if payment is to be issued to my provider, I must enclose an itemized statement with my provider's payment address.

I certify the listed expenses on the back of this form have been incurred by me and/or my dependents during the Plan Year and qualify for reimbursement. I also understand these expenses no longer qualify as tax deductions or credits. The itemized statements, EOB's, or other evidence of these expenses are attached.

I understand that any physician, hospital, or other organization or person having any records, data, or information concerning health history or other insurance for me or my dependents, may furnish such records, data or information as may be requested by MEBS, Inc.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Send Claims to: MEBS, Inc.  
3809 Lake Eastbrook Boulevard S.E.  
Grand Rapids, Michigan 49546  
(616) 458-3495

**List Expenses for  
HEALTH (MEDICAL, DENTAL , VISION and PRESCRIPTION) AND HRA  
REIMBURSEMENT**

Description of Eligible Expenses	Name/Relationship of Person(s) the Expenses are for	Dates of Service	Payment To*	Reimbursement Requested
			<input type="checkbox"/> Provider <input type="checkbox"/> Employee	
			<input type="checkbox"/> Provider <input type="checkbox"/> Employee	
			<input type="checkbox"/> Provider <input type="checkbox"/> Employee	
			<input type="checkbox"/> Provider <input type="checkbox"/> Employee	
			<input type="checkbox"/> Provider <input type="checkbox"/> Employee	
			<input type="checkbox"/> Provider <input type="checkbox"/> Employee	
			<input type="checkbox"/> Provider <input type="checkbox"/> Employee	
			<input type="checkbox"/> Provider <input type="checkbox"/> Employee	
			<input type="checkbox"/> Provider <input type="checkbox"/> Employee	
<b>TOTAL HEALTH and HRA REIMBURSEMENT REQUESTED</b>				

\*NOTE: Based on your group's plan design, you may not be authorized to choose whether payment be made to the Provider or to yourself. Please refer to your summary plan description (SPD) for payment options.

**List Expenses for  
FLEX and DEPENDENT CARE REIMBURSEMENT**

Description of Eligible Expenses	Name/Relationship of Person(s) the Expenses are for	Dates of Service	Payment To	Reimbursement Requested
			Employee	
			Employee	
			Employee	
			Employee	
			Employee	
			Employee	
<b>TOTAL FLEX and DEPENDENT CARE REIMBURSEMENT REQUESTED</b>				