EAGLE RIDGE
Corporate Services

Healthcare Expense Reimbursement Claim Form

Employers Name_____

Participant's Name: _____SSN: _____

Change of Address Information: _____

Please list only amounts for which you are requesting reimbursement. DO NOT include any amount that will be paid by any other health plan such as your health insurance policy or HMO.

Date Incurred	Name of Service Provider	Describe expense	Person for whom Expense Incurred	Amount to reimburse

TOTAL: _____

IMPORTANT: You must attach third party proof of your claim (such as itemized bills, receipts or invoices) for all expenses claimed. The IRS requires the **date** the service was received, the **name** of the service provider and the **amount** of the expense. The IRS does NOT allow a statement of forward/previous balance.

READ CAREFULLY: The undersigned plan participant certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period in which the undersigned was covered under the employer's plan with respect to such expenses and that the medical expenses have not been reimbursed and are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim provided by the undersigned. Unless an expense for which payment or reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for payment of all related taxes including federal, state or local income tax on amounts paid from the plan which relate to such expense.

_____ _____

Participant's Signature Date

Mail or fax to: Eagle Ridge Services
PO Box 2640
Sioux City, IA 51106-0640
Or scan to: claims@eagleridgeservices.com

Phone: 712-274-6725
Toll Free: 800-301-6692
Fax: 712-274-6726