



innovative insurance solutions

Mail or Fax claim forms to:
rha
5502 58th Street, Suite 700
Lubbock, TX 79414
Voice: 800-680-0892
Fax: 806-784-3555

**Dental/Vision Reimbursement
Claim Form**

INSTRUCTIONS

1. Please complete all sections below.
2. If expense is covered by insurance, submit to appropriate 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		

EXPENSES

Patient Name	Description of Eligibility Expense	Incurring Dates	Total Amt of Bill	Amt to be Reimbursed

Provider Signature:	Date:
----------------------------	--------------

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 Dental/Vision 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 (<i>Required</i>)	Date
--	------