Medical Expense Reimbursement Plan Of The Health Professionals And Allied Employees Retiree Medical Trust

Administered by

Benserco, Inc.
140 Sylvan Avenue, Suite 303 , Englewood Cliffs, NJ 07632
(201) 947-8000 (201) 947-9192 Fax

Medical Expense or Premium Reimbursement Claim Form

Name: _____

Street Address: _____

City/State/Zip: _____

S.S. # _____ - _____ - _____

If Claim by Beneficiary, complete for Beneficiary:

Name: _____

Address: _____

S.S. # _____ - _____ - _____ **Telephone # ( ) _____**

At the time I incurred the expenses I am claiming, I ☐ was ☐ was not employed by an employer that contributes to the HPAE Retiree Medical Trust. If you were employed by a contributing employer at the time the expense was incurred, please list the name of the employer _____
Last Date worked _____

Instructions to submit claims for reimbursement:

1. Reimbursement will be made directly to the participant or eligible beneficiary; they cannot be assigned to the provider. Claims are processed monthly.
2. Please submit expenses covered by other medical and/or dental plans to those plans first.
3. Each submission must have corresponding documentation such as an EOB or a receipt for a co-pay or bills showing amount and nature of expense; period of time or date incurred covered by the bill and the address or Tax ID of the service provider.
4. Claims and supporting documentation become the property of the Plan and *cannot be returned to you*. If you wish to keep copies, please make them before you submit the claim.
5. All expenses must be itemized and allowable under the Plan guidelines. (For a definition of "Covered Expenses" please refer to Sec. 1.6 of the Plan.)

Premium Period or Service Date	Provided For *(Circle one or more)*	*(Circle one)* Premium/Expense / Carrier or Provider	Type of Service/Coverage *(Circle one)*	Amount Requested	Administrator Use Only
	Name: _____ Self Spouse Dependent		Medical Dental Vision Other: _____	$_____.__	
	Name: _____ Self Spouse Dependent		Medical Dental Vision Other: _____	$_____.__	
	Name: _____ Self Spouse Dependent		Medical Dental Vision Other: _____	$_____.__	
	Name: _____ Self Spouse Dependent		Medical Dental Vision Other: _____	$_____.__	
			Total Requested	$_____.__	

Service Date: When you or your eligible dependent received the care or service; Premium Period: Month(s) covered by Premium payment; Provided For: Who received service; Provider Carrier: Who provided the care, service or coverage; Type of Coverage or Service: Please circle one; Amount Requested: Cannot exceed your out-of-pocket expense after insurance payment or reimbursement from other sources.

I certify that the above claim(s) submitted for reimbursement by me to the HPAE Reimbursement Plan was incurred for services or premiums on behalf of me or my eligible dependents and, to the extent covered by another health plan, have been first processed for payment by that plan to the best of my knowledge. I certify that I am not eligible for or have been reimbursed for the expenses by any other entity. I understand that expenses reimbursed through the Plan are not allowed as deductions or credits when filing my individual income tax return.

Type of Documentation attached: _____

_____ Participant or Beneficiary Signature

_____ Relationship to Retiree

_____ Date Signed

Please do not write below this line; for Administration use only

Notes:

Check #_____ issued on (Date) _____ for the amount of $ _____

Claim Adjudicated by (initials) _____

Claims audited and paid by (initials) _____