MEBS
Better Decisions. Better Healthcare.

Payment Request

Please select payment type(s):

Medical **Prescription** **Dental/Vision** **Flex** **HRA**

Step 1. Please complete your contact information.

Employer: ______________________ Date: ______________________

Name: ______________________ Phone: ______________________

Home Address: ____

____

Email Address: ______________________ Social Security #: _____ – _____ – _____

Step 2. Please complete the expense form on page 2 and follow these important instructions.

For a 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 are covered by any other insurance carrier or plan, you must attach the EOB from that carrier.

For a 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.

For a 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.

Step 3. Please sign and date.

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: ______________

Step 4. Send Claims to:

MEBS - Claims
3809 Lake Eastbrook Blvd SE
Grand Rapids, Michigan 49546

Tele: (800) 968-6327

Or Fax to: (616) 458-3495
Attn: MEBS - Claims

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
			Provider Employee	
			Provider Employee	
			Provider Employee	
			Provider Employee	
			Provider Employee	
			Provider Employee	
			Provider Employee	
			Provider Employee	
			Provider Employee	
TOTAL HEALTH and HRA REIMBURSEMENT REQUESTED				

*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	
TOTAL FLEX and DEPENDENT CARE REIMBURSEMENT REQUESTED				