

# Unreimbursed Medical Reimbursement Claim Form

**ELKIN & ASSOCIATES, LLC**

Fax: 1-800-598-6844

P.O. Box 35470

Charlotte, NC 28235

Account information: [www.elkinassociates.com](http://www.elkinassociates.com)

Customer Service: 1-800-598-6843

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

Employee Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

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<b>Unreimbursed Medical Expense Claims</b>				
<b>Date Expense Incurred</b>	<b>Name of Service Provider</b>	<b>Expense Description</b>	<b>Person for Whom Expense Incurred</b>	<b>Net Amount</b>
<b>➡ Attach appropriate receipt(s) and submit with this claim form.</b>			<b>Total Medical Care Expense Claim \$</b>	

**Read Carefully:** The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed or 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 which is provided by the undersigned, and that 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 city income tax on amounts paid from the Plan which relate to such expense.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

# Medical Claim Filing Instructions

Claim Forms & Reimbursement Schedules available at [www.elkinassociates.com](http://www.elkinassociates.com)

**1**

## Gather Receipts & Claim Form

Receipts must include date(s) and details of service.

Service must be incurred during the Plan Year.

Cancelled checks or credit card receipts are not acceptable per IRS rules.

If claim is for an insurance deductible, an EOB (Explanation of Benefits) from the insurance company must be submitted.

**2**

## Complete and Sign the Claim Form

Attach receipts and sign the claim form.

Keep copies for your records.

**3**

## Submit Claim & Receipts to Elkin & Associates

Via Fax °

800-598-6844

Or Via Mail \*

Claim Processing  
Elkin & Associates, LLC  
P. O. Box 35470  
Charlotte, NC 28235



Customer Service:  
800-598-6843

Avoid Mail Delays  
Sign up for Direct Deposit  
For your Reimbursement