Medical Services Reimbursement Request

CLAIMANT INFORMATION

Full Name

Address

Phone Number

Email

PATIENT INFORMATION (IF DIFFERENT FROM CLAIMANT)

Patient Name

Relationship to Claimant

Date of Birth

MEDICAL SERVICE DETAILS

Date of Service	Provider Name	Type of Service	Amount Charged	Amount Paid	Amount Requested

Total Amount Requested

SUPPORTING DOCUMENTATION

- Attach itemized bills for all services
- Attach proof of payment
- Include copies of Insurance Explanations of Benefits (if available)

CLAIMANT DECLARATION

I hereby certify that the information provided is true and correct to the best of my knowledge.

Claimant Signature

Date

Note: Submission of this form does not guarantee reimbursement. All requests are subject to verification and plan guidelines.