

# PCI HEALTH BENEFIT PLAN

## *Reimbursement Request Form*

Instructions: Please print or type and complete all items under **Personal Information**. In order to receive reimbursement, you must submit an *Explanation of Benefits Statement* (if applicable) from your insurance carrier, or an itemized statement that includes the provider name, patient name, date of service, description of service, insurance responsibility (if applicable), and patient responsibility for each health care claim. You must sign and date this form and attach any corresponding receipts in order for us to process this claim. You have permission to photocopy this form.

PERSONAL INFORMATION	
Tribe's Name	Email Address
Member's Name	Date of Request
Member's Tribal Roll Number	Daytime Phone Number

HEALTH CARE EXPENSES					
Patient Name	Relationship	Age	Date of Service	Type of Service (Medical, Dental, Premiums, etc.)	Requested Amount
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
<b>Total:</b>					

*I, the undersigned, hereby certify that the above listed expenses have not been previously reimbursed from my Flexible Spending Account, nor are reimbursable from any other source. I hereby authorize Flexible Corporate Plans, Inc. to obtain necessary information from all physicians, hospitals, Tribes and all other agents in order to adjudicate the claim for reimbursement under the Plan established by my Tribe.*

\_\_\_\_\_  
Member Signature

\_\_\_\_\_  
Date

**Flexible Corporate Plans, Inc.**

P.O. Box 381717, Birmingham, AL 35238 ♦ (205) 995-1222 ♦ Toll Free: 1-888-505-4557 ♦ Fax: (866) 238-8224