AgriPlan® BizPlan®

# Request for Reimbursement Form

Name: _____

TASC ID: _____

FOR EACH CLAIM ENTERED, ALL BOXES MUST BE COMPLETED.

| Date of Service Month / Day / Year | Benefit Code | Amount Requested | Service Provider | Name of Patient/Insured |
|---|---|---|---|---|
| _____ | _____ | _____._____ | _____ | _____ |
| _____ | _____ | _____._____ | _____ | _____. |
| _____ | _____ | _____._____ | _____ | _____ |
| _____ | _____ | _____._____ | _____ | _____ |
| _____ | _____ | _____._____ | _____ | _____ |

**BENEFIT CODES:**
**ME – Medical Expense RX – Pharmacy Expense HP –Premium DP- Dental Premium VP- Vision Premium**
**LT- Long-term Care premium DI- Disability Insurance LI- Life Insurance**

To the best of my knowledge and belief, my statements in this Request for Reimbursement are complete and true. I am requesting reimbursement for eligible expenses incurred during the applicable Plan Year and for eligible Plan Participants. I certify that these expenses have not previously been reimbursed under this or any other benefit Plan and will not be claimed as an income tax deduction. In addition, if required by Plan design, I have depleted all available Flexible Spending Accounts before submitting this claim.

Participant Signature (required) _____ Date _____ / _____ / _____

**REIMBURSEMENT TIPS to ensure prompt and accurate reimbursements:**

- This form is for use with manual claim reimbursement with your employer .
- Include all required claim substantiation for your specific plan (i.e. EOB) with your Request for Reimbursement form.
- Please duplicate this form for future claims.
- Dates of service always represent the date your services are incurred or rendered, not the date they were paid.
- Enter the amount requested for each claim. One request form can be used for multiple expenses.
- Your signature is required on each Request for Reimbursement Form.