DAT E RECEIVED

MSMA USE ONLY

MSMA GROUP INSURANCE TRUST CHOICE PLAN
MEDICAL CARE EXPENSE REIMBURSEMENT REQUEST

INSTRUCTIONS: Complete this form and attach a copy of your insurance company's statement (EOB). If you do not have insurance attach receipts, which include a description of the expense, patient name, date(s)-of-service, amount paid, and the provider's name, address. If you have a managed care program, please attach a receipt for your co-pay from the provider's office. To help expedite your claim form request please make sure your receipt states "co-pay" on it. **Do not send copies of checks or charge-card receipts.**

FOR A CURRENT LIST OF REIMBURSABLE EXPENSES PLEASE GO TO OUR WEBSITE @ WWW.MSMAWEB.COM

Employee Name: ________________________________ Employer: __________________________

Please fill out the information only if a change has taken place since your enrollment or last claim submission

Home Phone:______________ Work Phone: __________________

Mailing Address:____

*Please list the **name and relationship** of all dependents for whom expenses were incurred*:

NAME RELATIONSHIP

____

____

____

TOTAL EXPENSES SUBMITTED$_______________

CERTIFY THAT: all items submitted for reimbursement comply with the Section 125 Reimbursement Plan and such items have not and will not be paid by any other plan of any employer or any other person. I also certify that such items will not be deducted or taken as tax credits on my personal federal or state income tax return any year.

EMPLOYEE SIGNATURE: ____DATE:______________

Send your request for reimbursement to:

MSMA-GIT/125
49 Community Drive
Augusta, ME 04330

Please call with any questions:

In state: 1-800-660-8484
Out of state: (207) 622-3473

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APPROVED ________________ DATE _________________

DATE PAID ________________CHECK#________________

CLAIM NUMBER____

CLAIMS CANNOT BE FAXED

PY **1** : PY **2**

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