

DATE RECEIVED

MSMA USE ONLY

MSMA GROUP INSURANCE TRUST CHOICE PLAN MEDICAL CARE EXPENSE REIMBURSEMENT REQUEST

INSTRUCTIONS: Complete this form and attach receipts which include a description of the expense, patient name, date(s)-of-service, amount paid, the provider's name, address and federal tax-payer identification number. **If available, please attach a copy of your insurance company's statement (EOB) showing that the expense was not paid by your insurance plan.** 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.*

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:** _____

Please Note: Special Rules For Orthodontic Care

- Orthodontic expenses are reimbursed after the service is provided, not when the expense is paid.
- The total cost for braces cannot be reimbursed at the time the appliance is installed, even if it has been paid in full.
- Reimbursements are allowed according to the monthly fee stated in the contract or service agreement drawn between the orthodontist and patient. Initial down payments are also reimbursed according to the contract.
- If treatment is provided without a contract or service agreement, or if the total cost of the braces is paid upfront, reimbursements will be apportioned by dividing the total cost by the number of office visits required to complete the treatment. The orthodontists must provide written documentation of the apportioned amounts.
- Initial requests for reimbursement should include a copy of the orthodontic care contract.

Send your request for reimbursement to:

MSMA-GIT/125
49 Community Drive
Augusta, ME 04330-9405

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 CAN NOT BE FAXED

PY 1 : PY 2