THE NEW SCHOOL

MAIL or FAX TO: EBPA REIMBURSEMENT ACCOUNTS
P.O. BOX 1140
EXETER, NH 03833-1140
Phone: 888-678-3457
Fax: 603-773-4415

HEALTH CARE REIMBURSEMENT REQUEST FORM

NAME	SOCIAL SECURITY NUMBER
ADDRESS (STREET)	EMPLOYER THE NEW SCHOOL
ADDRESS (CITY, STATE, ZIP CODE)	

- List reimbursable expense and attach explanation of benefits or itemized bill.
- Identify each expense as M (Medical), D (Dental), V (Vision), H (Hearing), or O (Other), under Type of Expense.
- If an expense is covered in part by a health plan the balance may be submitted for reimbursement only after all health plan benefits from all sources have been paid. A copy of the health plan's payment voucher or denial must be submitted with the claim. If no health plan applies write "none" in the Plan payment column.
- Attach a second form if you need additional space.

TYPE OF EXPENSE	EXPENSE FOR:	DATES OF SERVICE:		TOTAL BILL (ATTACH COPY)	PLAN PAYMENT (ATTACH PAYMENT OR DENIAL)	AMOUNT OF REIMBURSEMENT DUE
	NAME	FROM	TO			
			TOTALS			

1. I certify that the above listed expenses have been incurred by me or my eligible dependents (as defined by the IRS).
2. I certify that all applicable insurance or other health benefits have been exhausted.
3. I certify that I will not deduct or take as a tax credit on my Federal Income Tax Return these reimbursements.
4. I will assume all responsibility for taxes or penalties arising out of any disallowed deductions.
5. I have received the taxpayer ID # of my care provider.

ALL DISBURSEMENTS FROM THE REIMBURSEMENT ACCOUNTS WILL BE MADE PAYABLE TO THE EMPLOYEE

SIGNATURE_____ DATE:_____

ebpa