

Expenses must be incurred while the employee is eligible for the plan, not to exceed the limit for any one calendar year

ANTELOPE MEMORIAL HOSPITAL Medical Reimbursement Plan

A. Please attach:

1. Copy of bill with date(s) of service, provider, patient, total amount of charges and/or
2. Explanations of benefits from insurance and/or third party payor.

1. Patient's Name					
	<u>Please Circle One</u>	<u>Please Circle One</u>	<u>Please Circle One</u>	<u>Please Circle One</u>	<u>Please Circle One</u>
2. Relationship to Employee	Self Spouse Child	Self Spouse Child	Self Spouse Child	Self Spouse Child	Self Spouse Child
3. Date of Birth					
4. Date(s) of Service					
Location of Service	<u>Please Circle One</u>	<u>Please Circle One</u>	<u>Please Circle One</u>	<u>Please Circle One</u>	<u>Please Circle One</u>
5. Hospital or Clinic	Hospital Clinic	Hospital Clinic	Hospital Clinic	Hospital Clinic	Hospital Clinic
6. Total Amount of Bill	\$	\$	\$	\$	\$
7. Amount Insurance Paid	- \$	- \$	- \$	- \$	- \$
8. Amount Other Insurance or Third Party Paid	- \$	- \$	- \$	- \$	- \$
9. Provider Adjustment or Discount	- \$	- \$	- \$	- \$	- \$
10. Balance after Insurance (payments/adjustments)	\$	\$	\$	\$	\$
11. 10% of Amount on line 6 or Balance remaining on line 10, (if line 10 is less than 10%)	\$	\$	\$	\$	\$
12. Balance Owed (Hospital/Clinic)	\$	\$	\$	\$	\$

I certify that the information listed above is correct and qualifies under the Antelope Memorial Hospital Reimbursement Plan.

Signature: _____

Date: _____

**Additional
on Back**