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, and the provider's name, address. **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.*

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

F/data/125/form/mcaform