MEDICAL REIMBURSEMENT CLAIMS AFFIDAVIT

COMPANY _____

NAME _____

SOCIAL SECURITY # _____

Please indicate the amount of the expenses you have incurred. Retain a copy for your records.

UNREIMBURSED MEDICAL EXPENSE FOR INPATIENT CARE (DEDUCTIBLE OR CO-PAY) $ _____

(Include written statements (e.g., **Explanation of Benefits**) substantiating the expenses claimed on this affidavit from all third party providers.)

I HEREBY CERTIFY that his claims affidavit does not include any amounts that have been reimbursed or are reimbursable under any other health plan. I further understand that I cannot deduct any expenses for which I am reimbursed on my individual Federal and State income tax returns.

SIGNED _____ DATE _____

EACH RECEIPT NEEDS:

1) EMPLOYER NAME
2) NAME OF PATIENT
3) DATE OF SERVICE
4) SERVICE RECEIVED
5) NAME & ADDRESS OF CAREGIVER
6) COST OF SERVICE

SEND TO:

PETER ZAPPA & ASSOCIATES
P.O. BOX 2749
NORTH ATTLEBOROUGH, MA 02763
1-800-659-0527
FAX 1-508-285-4607

PLEASE ATTACHED A **PHOTOCOPY** OF THE EXPLANATION OF BENEFITS
CANCELLED CHECKS ARE **NOT** ACCEPTABLE RECEIPTS