TREDYFFRIN TOWNSHIP
MEDICAL REIMBURSEMENT FORM

EMPLOYEE / RETIREE INFORMATION

Employee or Retiree Name:	
Address (Street, City, State, Zip):	

EXPENSE INFORMATION

Date (s) of Service	Patient's Name	Relationship to Employee (self, spouse, dependent)	Health Care Professional / Provider	Reimbursement Request Amount $
TOTAL				

To the best of my knowledge and belief, my statements on this request are complete and true. I understand that I am solely responsible for the validity of claims submitted. I am claiming reimbursement only for eligible expenses incurred by myself, spouse and / or covered dependents and certify that these expenses have not been previously reimbursed by this plan.

Employee / Retiree Signature		Date	