

REQUEST FOR Rx REIMBURSEMENT

Please mail, or fax completed form to:

AmeraPlan, Inc. - 3001 West Big Beaver, Suite 320, Troy, Michigan, 48084

Phone - 800.221.4254

Fax - 248.643.9401

Instructions:

1. Complete the form in its entirety.
2. Attach Pharmacy receipt, detailing patient, prescription and co-pay amount.
3. Attach Proof of Payment.
4. Fax completed form, Pharmacy Receipt and proof of payment to: 248.643.9401.

Failure to provide these items will result in a denial of claim, until all missing items are received.

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|--|--------------|--------------------------|--|
| EMPLOYEE INFORMATION: | | | |
| Company Name : | | Employee SSN #: | |
| Last Name: | First Name: | M.I. | |
| Street Address: | | Home Phone #: | |
| City: | State: | Zip: | |
| DEPENDENT INFORMATION (REQUIRED WHEN SUBMITTING CLAIMS FOR DEPENDENTS) | | | |
| Last Name: | | First Name: | |
| Relationship to Employee: | | (Circle One) | |
| Spouse | Child | Full Time Student | |
| <p>I request reimbursement for the expenses listed above. I am including a receipt or other appropriate third party proof of incurred expenses during the plan year, and during a period while the undersigned was covered under this plan. I have not been reimbursed for these expenses under our insurance plan, or under any other source.</p> | | | |
| <p>Amount Requested: \$ _____</p> | | | |
| Employee Signature | | Date Submitted: | |

Claims forms are available under the "Claimant Portal" at www.ameraplan.com

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