

**REIMBURSEMENT PROGRAM CLAIM FORM**

The reimbursement program is for any expenses incurred by the employee, his/her spouse, and/or eligible dependents. **These expenses can not be reimbursed by any other plan.** Please complete all sections of the form, attach copies of your bills and return to:

Fitzharris Benefits Administrators  
P.O. Box 9182  
Farmingdale, NY 11735-9182

{ Claim Office Telephone Number is: 516-777-2244 or 1-800-321-1336 }

Member's Name \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Address \_\_\_\_\_

Name of Member or Dependent	<i>Service Category Number</i>	Date of Service	Amount not covered by any other plan
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

***Service Category Number:***

- 1. **Optical**
- 2. **Major Medical Deductible**
- 3. **20% co-payment of the medical bill**
- 4. **Orthotic Devices**
- 5. **Hearing aids**
- 6. **Dental expenses**
- 7. **Medical expenses (not covered by/or in excess of any insurance plan)**
- 8. **Prescription co-payment**
- 9. **Other**

**Note:**

- (1) Please attach the copies of the bills and circle the amount not covered by any other plan.
- (2) If the claim form is not completed and the services are not completely itemized, processing of payment will be delayed until all required information has been submitted.
- (3) Orthotic devices and hearing aids must be submitted first to your health company and be rejected. Attach not only the bill but also the rejection letter from the health insurance form.