QUAD/GRAPHICS HEALTH CARE FLEX PLAN REIMBURSEMENT REQUEST

Reimbursement is available ONLY for amounts paid for medical care including diagnosis, cure, treatment, prevention of disease, or for the purpose of affecting any structure or function of the body. Any expenditure that is merely beneficial to the general health of an individual is not one for medical care and is not eligible for reimbursement.

INSTRUCTIONS:

- Complete the reimbursement section below.
- The following supporting documentation must be stapled to this request:
  - Explanation of benefits statement must be submitted if claim is covered, but not paid by any benefits plan (for example, the deductible or coinsurance)
  - Prescription receipts or printouts from the pharmacy showing item name
  - Receipts for eligible vision services not covered under a benefits plan
  - Detailed receipt (including price, purchase date, item description and provider name) for goods and services purchased for medical care, but not covered under a benefits plan
- Keep copies of supporting documentation for your records. *Quad/Med Claims will not return your forms or receipts.*
- Reimbursements will be made payable only to the employee whose name appears on the account.
- Submit this completed request form and the related receipts to: Quad/Med Claims
  555 S. 108th St.
  West Allis, WI 53214
- Questions on your reimbursement should be directed to Quad/Med Claims at 414-566-6800 or 800-937-2230

Receipts submitted more than 60 days after termination of benefits or end of plan year will not be reimbursed.

_____ _____

Print Employee Name | Employee Social Security Number

_____

Street Address

_____

City | State | Zip Code

Print Patient Name	Relationship to Employee	Date of Service	$ Amount of Claim

Total Submitted Amount $ _____

I certify that these expenses are for medical care, as described above, and have been incurred by me and/or my eligible dependents and are not payable by any other insurance plan. I further declare that I have not and will not deduct these expenses on my Federal, State or local income tax returns.

_____

Employee Signature | Date