



Section 125 Medical Reimbursement Request Form

Section 1 This section must be completed fully for all claims. (PLEASE PRINT)

EMPLOYER NAME: _____

EMPLOYEE NAME: _____

ADDRESS: _____

Check if this is a NEW address EMPLOYEE DAY TIME PHONE NUMBER: _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

Section 2 This section must be completed for all claims incurred by you, your spouse, or other eligible dependents. Supporting documentation **MUST** be attached. We want to promptly process your claims. Please complete all appropriate sections as the claim form will be returned to you if incomplete. Use an additional form if you need more space. Please keep a copy of this form for your records.

EXPENSES

Item	Service Dates	Provider Of Service	Description Of Service	Amount Requested
1				\$
2				\$
3				\$
4				\$
5				\$
6				\$
7				\$
8				\$
9				\$
10				\$
11				\$
12				\$
13				\$
14				\$
15				\$
TOTAL AMOUNT REQUESTED				\$

Section 3 Employee's Signature is required to process this claim.

AUTHORIZATION: I authorize any medical professional, hospital, other medical facility or provider to disclose to Envision Healthcare, Inc. information concerning care, treatment or billing for any treatment I obtained at that facility. This authorization shall expire on the date in which my employer terminates coverage with Envision Healthcare, Inc. I also understand that I may revoke this authorization at any time, but that such revocation will have no effect on any actions taken by Envision Healthcare, Inc. prior to receipt of revocation. I understand that information disclosed pursuant to the authorization may re-disclosed and no longer protected by federal privacy laws. I authorize Envision Healthcare, Inc. to transmit the information contained electronically.

To the best of my knowledge, my statements in the request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the application plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plans and will not be claimed as an income tax deduction. I authorize my FlexPay medical accounts to be reduced by the amount requested.

SIGNATURE: _____ **DATE:** _____

Envision Healthcare, Inc.

P.O.Box 5047, Oak Brook, Illinois 60522 | Tel: 1-866-672-7526 | Fax: 1-800-596-3464 | Email: info@ envisionhealthcare.com | www.envisionhealthcare.com