****If Faxing

 **HEALTH BENEFIT REIMBURSEMENT CLAIM FORM**

# of Pages:

**MEMBER INFORMATION** *(Please Print)*

Check here if address has changed

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  |  Tribal ID: |  |
| Address: |  |  Email : |  |

# City, State, Zip: Day Phone:

**READ CAREFULLY**

|  |
| --- |
| **UNREIMBURSED EXPENSES** *(Attach supporting documentation)* |
| Does your receipt include all of the following? |  | Provider's name and address Patient's nameService description Amount billedDate of service **\*\*\* Credit card receipts are not acceptable \*\*\*** |
| Person for WhomExpense was Incurred | Date(s)of Service | Name of ServiceProvider | Description of Services | Amount |
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|  | **Total Unreimbursed Expenses** |  |

The above is a true and accurate statement of all expenses incurred by my eligible dependents or me on the date(s) indicated, and I will not seek reimbursement from any other plan including a Health Savings Account (HSA). I understand that I cannot claim any reimbursed expenses on my income tax return, and that I may be liable for payment of all related taxes including Federal, State, or City income tax and any associated penalties on the amounts paid for any expense improperly claimed under the provisions of this plan.

|  |  |
| --- | --- |
| Participant Signature: |  |
| Date: |  |

**Mail To**: 4 Main Street Peterborough, NH 03458

**Fax To:** 603-925-1357

**Email To**: osagenation@rtconsultingllc.com

**Access your account information 24 hours a day, seven days a week on our web site:**

 **https://osagehealthbenefit.wealthcareportal.com**