HEALTH BENEFIT REIMBURSEMENT CLAIM FORM

If Faxing # of Pages: ☐

MEMBER INFORMATION *(Please Print)*

Check here if address has changed ☐

Name: _____ Tribal ID: _____

Address: _____ Email : _____

City, State, Zip: _____ Day Phone: _____

UNREIMBURSED EXPENSES *(Attach supporting documentation)*

Does your receipt include all of the following?
Provider's name and address
Service description
Date of service
Patient's name
Amount billed
*** Credit card receipts are not acceptable ***

Person for Whom Expense was Incurred	Date(s) of Service	Name of Service Provider	Description of Services	Amount
		Total Unreimbursed Expenses		

READ CAREFULLY

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