BALDWIN-WALLACE COLLEGE
MONTHLY CLAIM FORM FOR THE YEAR ________
UNINSURED MEDICAL CARE REIMBURSEMENT ACCOUNT
(Please Fill Online or Print Legibly)

Employee Name: ____

Department: ______________________________ **Ext:** ___________

Home Address: ____

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Medical or dental care covered by Medical Mutual or Kaiser: ***Submit Medical Mutual or Kaiser claim first***. After you receive their payment, submit their Explanation of Benefits sheet (EOB) with this claim form to obtain reimbursement for the amount of your expenses they did not pay.
Other medical costs: Submit billing statements and/or detailed receipts of providers (physicians, hospitals, opticians, over-the-counter medicines, etc.) for reimbursement for eligible items not covered by Medical Mutual or Kaiser. Taxes for OTC (Over the Counter) drugs, and other supplies are not reimbursable.
Note: On the reverse side of this form, fill out expenses submitted.

Certification: I certify that the medical expenses for which I am asking reimbursement in this claim are allowable expenses that have not been reimbursed by any other plan and are not eligible for reimbursement by any other plan.

______________________________________ ________________
Employee Signature Date

Send both sides of this form with attachments in a sealed envelope to Lisa Giesen, Finance Office, before the 20th of the month. We pay claims monthly on the 30th, in a single check payable to the employee. Claims received after the 20th will be paid the following month.

US Mail Campus Mail Hold Check Phone Number

Office Use Only

Approved ☐ Date ________ Account Balance ________ Date ________

Expenses Submitted

Provider's Name	Patient's Name	Relationship To Employee	Dollar Amount