



Police & Fire Retiree Medical Trust

Health Reimbursement Request Form

Check if new Address

Name: _____
 Address: _____

Retiree ID: _____
 Phone: _____
 Email: _____

	Expense #1	Expense #2	Expense #3	Expense #4	Expense #5	Expense #6
Date medical service actually provided						
Name of person receiving medical service						
His/her relationship to you	<input type="checkbox"/> Self	<input type="checkbox"/> Self	<input type="checkbox"/> Self	<input type="checkbox"/> Self	<input type="checkbox"/> Self	<input type="checkbox"/> Self
	<input type="checkbox"/> Spouse	<input type="checkbox"/> Spouse	<input type="checkbox"/> Spouse	<input type="checkbox"/> Spouse	<input type="checkbox"/> Spouse	<input type="checkbox"/> Spouse
	<input type="checkbox"/> Dependent	<input type="checkbox"/> Dependent	<input type="checkbox"/> Dependent	<input type="checkbox"/> Dependent	<input type="checkbox"/> Dependent	<input type="checkbox"/> Dependent
Proof of expense attached	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
Total Expense						
Amount reimbursed previously or paid/payable under another plan						
Reimbursement Requested						

To the best of my knowledge and belief, my statements in this Form are complete and true. I certify all of the following: Either I have or my family member has received the services described above on the dates indicated, and the expenses are my out of pocket expenses that qualify as eligible Medical Care Expenses under the Plan. If the expense is for my Spouse or Dependent, the person listed is my Spouse or Dependent as defined by the Plan. I have not been reimbursed previously for these expenses. These expenses have not been reimbursed or are not reimbursable under the major medical plan or any other health plan. If the reimbursement requested is for prescribed drugs, such drugs are not prescribed for cosmetic purposes (hair growth, weight loss, etc.). I understand that the expenses reimbursed may not be used to claim any federal income tax deduction or credit, or to claim reimbursement under another medical plan. I authorize a deduction from my HRA Account for the expenses listed above.

Retiree Signature _____

Date _____

For Office use only	Amount Approved	Date Approved	Approved by:
Reason Expense Denied:			
<input type="checkbox"/>	Please sign		
<input type="checkbox"/>	Provide substantiation indicating what service or product was purchased.		
<input type="checkbox"/>	Ineligible Expense		
<input type="checkbox"/>	Other:		

Reimbursement Request Process

Important Dates: Reimbursement claim forms received by the plan administrator on or before the 25th day of each month will be processed beginning the first business day of the following month. Reimbursement checks are mailed within ten days thereafter.

Health Reimbursement Request forms submitted after the 25th of the month will be held and processed during the next claim cycle.

Only expenses submitted on the approved PFRMT Health Reimbursement Request Form will be considered.

You may submit reimbursement claims **NO LATER THEN 365 DAYS** after the end of the calendar year in which the expense is incurred.

Retiree ID numbers are located on the members' quarterly financial statements.

Each expense must be listed separately. For each expense include the date of service, name of person receiving the service and his/her relationship to you.

Copies of supporting documentation that indicates what product or service was rendered are required for each expense listed on the form to satisfy substantiation requirements for medical reimbursement. Originals should not be provided unless requested by the plan administrator. Please keep a copy of all forms and receipts for your records.

Incomplete or ineligible reimbursement claims will be responded to in writing.

Eligible medical expenses not covered by insurance or other means can be considered for reimbursement by the Police and Fire Retiree Medical Trust (PFRMT).

Health Reimbursement Request Forms are available on the Police Fire Retiree Medical Trust website at www.muni.org/pfrmt. For those retirees without internet access a form can be mailed upon request.

Submit forms:

Mail: Police & Fire Retiree Medical Trust
PO Box 196650
Anchorage, AK 99519-9980

Fax: 907-249-7622

Email: bretzld@muni.org

If you have any questions regarding this form or your benefits, please, contact the Plan Administrator at (907) 267-5094 or (877) 343-8203.