



UTICA COMMUNITY SCHOOLS
TEACHERS –MEDICAL PLAN
In-Network Deductible Reimbursement Form/Cover Sheet

IMPORTANT Note for Section 125 or Flexible Spending Account (FSA) subscribers:

Check IRS regulations for eligibility of non-reimbursed medical expenses under your Section 125 or Flexible Spending Account. Any amount reimbursed by EHIM under the Special Medical Reimbursement is not eligible under the Section 125 or Flexible Spending Account.

TO: EHIM- MEDICAL CLAIMS DEPARTMENT	FROM:
COMPANY: EHIM	DATE:
FAX NUMBER: 1-248-945-4887	TOTAL NO. OF PAGES INCLUDING COVER:
PHONE NUMBER: 1-248-948-9900	PHONE NUMBER:
RE: DEDUCTIBLE REIMBURSEMENT*	FAX NUMBER:

- Please note: The Out-of-network deductible is not reimbursable under this program.
- All claims must be submitted to EHIM within 45 days of date on your primary insurance EOB.

INSTRUCTIONS:

1. Complete this form.
2. Fax or Mail this form and your Primary Insurance Explanation of Benefits (EOB) to EHIM.
3. If you need a copy of your EOB, please go online to your primary insurance’s website (www.messa.org) and print and fax a copy. Utica Community School’s intranet will have instructions if needed.
4. **Please pay your provider any amount due.** EHIM will be reimbursing you for claims that were applied to your in-network single or family deductible.
5. **Retain a copy of this form and EOB for your records.**

Important! Please read and sign below:

Cardholder Certification: I certify that I (or my eligible dependent) have received the services described herein and that the plan participant named is eligible for REIMBURSEMENT benefits. I certify that all the information entered on this form and submitted with the form is correct. Any person who knowingly and with intent to defraud any insurance company or files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signature of Cardholder

Date

If you should have any questions regarding the reimbursement process, please call the EHIM Medical Department at 248-948-9900.

Privacy Statement: *The information on this form is legally privileged and confidential information intended for the use of the individual(s) named above. If you, the reader of this form, are not the intended recipient, you are hereby notified that you should not further disseminate, distribute, or forward this form. Thank you!*