GreenTree Administrators

Health Reimbursement Account

www.greentreeadmin.com

Pay Me Back Claim Form

FAX: 409-832-2301

Or mail to: Claims Administrator, PO Box 7306, Beaumont, TX 77726

ACCOUNT HOLDER INFORMATION

Last Name

First Name

Member ID Number off ID card

Birth Month/Day (MM/DD)

CERTIFICATION AND AUTHORIZATION

I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible expenses incurred on myself or an eligible dependent while I was a participant in the plan. I have already received these products and services and have not and will not seek reimbursement of this expense from any other plan or party. If I am covered under more than one health care account, reimbursement will be made according to the payment order determined by my Program Sponsor and as stated on the GreenTree Web Site.

Signature of Account Holder X ______________________________ Date ___________________________

CLAIMS FOR OUT-OF-POCKET EXPENSES

1 Rx Dental Psych/therapy Ortho
Co-payment Over-the-counter Chiro Hospital
Office Visit Vision Lab X-ray
Other: ____

Date of Service (MM/DD/YY)

. Out-of-pocket amount

Self Spouse
Child Other ____________________

____
Patient's Name

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YOU MUST ATTACH APPROPRIATE PROOF OF SERVICE FOR EACH AMOUNT ABOVE.

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TOTAL THIS FORM

MORE EXPENSES? Complete another form. QUESTIONS? See Instructions.