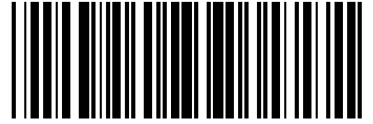




TOLL-FREE FAX: (877) 353 - 9236

Or, mail to: Claims Administrator, PO Box 14053, Lexington, KY 40512

DO NOT USE A FAX COVER SHEET to ensure speedy processing.



ACCOUNT HOLDER INFORMATION

Last Name and First Name input fields

Duke Unique ID* (last 4 digits) and Employer / Program Sponsor's Name input fields

Zip Code, Birth Month/Day (MM/DD), and Email Address (complete only if new) input fields

* Can't remember your ID? Check back of your ID badge or go to www.hr.duke.edu/benefits/reimbursement.

CERTIFICATION AND AUTHORIZATION

I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible expenses incurred by myself or an eligible dependent while I was a participant in the plan. (Patient & Relationship is assumed to be Self unless otherwise indicated.)

Signature of Account Holder X _____ Date _____

CLAIMS FOR OUT-OF-POCKET EXPENSES

INCOMPLETE FIELDS MAY RESULT IN YOUR CLAIM BEING DENIED

- 1. Rx, Dental, Psych / therapy, Ortho, Co-payment, Over-the-counter, Chiro, Hospital, Office visit, Vision, Lab, X-ray, Other: _____

Service Start Date (MM/DD/YY) and Out-of-Pocket Cost input fields

- Self, Qualifying Child, Spouse, Qualifying Relative, Other: _____

Patient's Name _____

Relationship to Account Holder _____

- 2. Rx, Dental, Psych / therapy, Ortho, Co-payment, Over-the-counter, Chiro, Hospital, Office visit, Vision, Lab, X-ray, Other: _____

Service Start Date (MM/DD/YY) and Out-of-Pocket Cost input fields

- Self, Qualifying Child, Spouse, Qualifying Relative, Other: _____

Patient's Name _____

Relationship to Account Holder _____

- 3. Rx, Dental, Psych / therapy, Ortho, Co-payment, Over-the-counter, Chiro, Hospital, Office visit, Vision, Lab, X-ray, Other: _____

Service Start Date (MM/DD/YY) and Out-of-Pocket Cost input fields

- Self, Qualifying Child, Spouse, Qualifying Relative, Other: _____

Patient's Name _____

Relationship to Account Holder _____

- 4. Rx, Dental, Psych / therapy, Ortho, Co-payment, Over-the-counter, Chiro, Hospital, Office visit, Vision, Lab, X-ray, Other: _____

Service Start Date (MM/DD/YY) and Out-of-Pocket Cost input fields

- Self, Qualifying Child, Spouse, Qualifying Relative, Other: _____

Patient's Name _____

Relationship to Account Holder _____

- 5. Rx, Dental, Psych / therapy, Ortho, Co-payment, Over-the-counter, Chiro, Hospital, Office visit, Vision, Lab, X-ray, Other: _____

Service Start Date (MM/DD/YY) and Out-of-Pocket Cost input fields

- Self, Qualifying Child, Spouse, Qualifying Relative, Other: _____

Patient's Name _____

Relationship to Account Holder _____

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

TOTAL THIS FORM input field

TOTAL THIS FORM

MORE EXPENSES? Complete another form.