Reimbursement Request Form Supplemental Plan

CONCIERGE Third Party Administrator

P.O. Box 4070, Bartlesville, OK 74006
P: 888.820.5687 | F: 918.333.9505 | E: Claims@cbscas.com

Check here if address has changed.

Part 1 – Employee Information (Please Print)

Name (First, Middle, Last)		
Date of Birth (mm/dd/yyyy)	Relation to Employee Spouse Child Self	
Address (Street, City, State, Zip)		
Email	Phone	Employer Name:

Part 2 – Health Care Expenses

DESCRIPTION OF EXPENSE AND REIMBURSEMENT AMOUNT REQUEST. Please Place Each Expense on a Separate Line.
Please include a copy of your Claim or Explanation of Benefits (EOB) for medical services provided.

Patient Name	Dates of Service		Description of Service	Provider of Service	Is this claim for the monthly Health Screening Benefit?
	From	To			

Part 3 – Employee's Certification For Reimbursement

I certify that the expenses being requested from the Supplemental Benefit Plan were incurred by me and to the best of my knowledge and belief are eligible for reimbursement. Any person who knowingly and with intent to injure, defraud, deceive, or files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Signature X	Date