**THE UNIVERSITY OF TENNESSEE FLEXIBLE BENEFITS PLAN**
**MEDICAL EXPENSE REIMBURSEMENT CLAIM FORM**

Employee Name (please print) ____________________________________________

I.D No. or Personnel No. _______________________________ Monthly ☐ Biweekly ☐

Office Telephone Number _______________________________ Expenses for Calendar Year 20 _______

## Claim Information

| Dates of Incurred Expenses | Employee/Dependent Name | Provider Of Service | Amount |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | Total of Reimbursement | |

I hereby certify that all expenses indicated above were incurred by me and/or my eligible dependents. I further certify that I have not previously received reimbursement for these expenses from any group insurance plan or The University of Tennessee Flexible Benefits Plan. I understand that I am solely responsible for the validity of claims submitted for reimbursement and that any expenses reimbursed through the Flexible Benefits Plan cannot be claimed on my personal Federal income tax return.

See reverse side for dependent eligibility and expenses eligible for reimbursement.

______________________________________ ______________________
Signature Date

**REQUIRED DOCUMENTATION FOR MEDICAL REIMBURSEMENT**

Each medical expense claimed on this form must be supported by an invoice or an insurance Explanation of Benefits (EOB) form. Each invoice should include:

Provider of Service / Provider Address/ Name of Patient
Dates of Expense / Amount of Expense

Return to:
The University of Tennessee
Payroll Office
P115 Andy Holt Tower
Knoxville, TN 37996-0100
(865)974-5251 (865)974-3530 fax

**DUE DATES**

Monthly: Claims must be received in the UWA Payroll Office by the 15th of the month (10th for December).
Biweekly: Claims must be received in the UWA Payroll Office on Monday the week before payday.