



CITY OF EAST LANSING RETIREE REIMBURSEMENT REQUEST



Employee Benefit Concepts, Inc.

If reimbursement includes services delivered to spouse, provide:

Retiree Name

Spouse Name

Retiree Social Security Number

Spouse Social Security Number

Street Address

City

State

Zip Code

Daytime Phone Number

For each reimbursement request, provide the following information

Patient Name	Date of Service	Type of Service (office visit, prescription, physical therapy, hospital copay, etc.)	Provider Name	Reimbursement Amount Requested
Total Amount Requested:				\$

I certify that this reimbursement request is for eligible medical expenses and that those expenses have been incurred.

Retiree Signature

Date

FAX to Employee Benefits Concepts, Inc., Attention Karen 248-932-7591
Or Mail to Employee Benefits Concepts Inc. PO Box 2365 Farmington Hills, MI 48333-2365 Attention: Claims Department

**For EACH reimbursement request for MEDICAL SERVICES, attach payment statements showing dates of service, payments and copayments
For EACH reimbursement request for PRESCRIPTION DRUGS, attach receipt with prescription number, patient name and copayment**