



P.O. Box 786010
 San Antonio, Texas 78278-6010
 (210) 357-1010 (800) 229-1024

FAST CLAIM FORM

The Fast Claim Form is being used for (please check one):

- Medical Reimbursement Claims Supplemental Medical Indemnity Claims Dependent Care/Adult Care Claims

Employee Name: _____ Employer Name: _____

Social Security Number: _____ Today's Date: _____

Name of Child Care Provider: _____ SSN or Fed. Tax ID No. of Provider: _____

PATIENT OR DEPENDENT NAME	DATE OF SERVICE	DESCRIPTION OF SERVICE	AMOUNT OF EXPENSE	HEALTH INSURANCE COVERAGE? Y/N
			\$	
			\$	
			\$	
			\$	
			\$	
			\$	
			\$	
			\$	
			\$	
TOTAL FROM OTHER SIDE			\$	
Signature of Childcare/Adult Care Provider: _____			Total \$	

PICKUP CHECK (Provide your phone number) (____) _____

CHANGE OF ADDRESS Name: _____
 Address: _____
 City, State, Zip: _____

AUTHORIZATION • CERTIFICATION

To Health Care Providers, Agencies, and Insurance Companies: you are authorized to permit a representative of Ameritas to obtain or view a copy of the records pertaining to the examination, treatment history, prescription and medical expenses of the Named Patient or Dependent for which reimbursement is hereby requested. Such information may be used to the extent deemed necessary by Ameritas to determine the validity of amounts payable on account of this claim.

I hereby certify that the expenses for which I am seeking reimbursement under the terms of the Plan were incurred for "medical care" for me, my spouse, and/or my dependent(s). "Medical care" for this purpose means amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. "Medical care" may include over-the-counter drugs if they meet the criteria above.

I understand that expenses for over-the-counter items are subject to substantiation and will only be reimbursed if allowed by my Section 125 Plan.

I certify that these expenses have not been reimbursed and I will not seek reimbursement for them under a major medical plan or any other health plan, such as an individual policy or my spouse's or dependent's health plan. I understand that the expense for which I am reimbursed may not be used to claim any federal income tax deduction or credit.

Signature _____ Date _____

MAIL COMPLETED FORM WITH APPLICABLE DOCUMENTATION TO THE ABOVE ADDRESS.
 INCLUDE ORIGINALS OF ALL DOCUMENTATION (ITEMIZED STATEMENTS, EOB'S, ECT.) FOR EXPENSES FOR WHICH YOU ARE REQUESTING PAYMENT.
KEEP COPIES FOR YOUR RECORDS.

