Miami Association of Fire Fighters Health Benefit Trust
2980 N.W. South River Drive, Miami, Florida 33125-1146
(305) 633-3442 Fax (305) 633-3935

Medical Reimbursement Form

Date: _____/_____/_____

Participant (Retiree) Information

*PT #1*____

____
Participant Name (*First, M.I., Last*) Participant SSN

____
Mailing Address City State Zip Code

____
Date of Birth Phone ( ) Sex (*M, F*)

Patient Information; COMPLETE ONLY IF DIFFERENT THAN ABOVE

Patient Name and #	Relationship to Participant	Date of Birth	Sex(*M, F*)
2			
3			
4			
5			

Type of Reimbursement (*List all that apply*): Healthcare Premium
Doctor Bill
Hospital Bill
Prescription Drugs
Other Qualified Medical Expense

I certify that the requested reimbursement is a qualified medical expense for myself or one of my eligible dependants as established in the Retiree Health Plan.

Send this reimbursement request and the attached itemized receipts to the address listed above

-- OVER --

Instructions:

Date: Use date of expense

Patient #: Use Patient number that is found on front side of form

Category #: Number to be used for table below

1. Healthcare Premium
2. Doctor Bill(s)
3. Hospital Bill
4. Prescription Drugs
5. Other Qualified Medical Expense

Description: Brief description of eligible expense

Date	Patient #	Category #	Description	Amount
			Total	**$**

Requires itemized receipts

I certify that the requested reimbursement is a qualified medical expense for myself or one of my eligible dependants as established in the Retiree Health Plan.

_________________________________ ______________________

Participants Signature: Date:

**Reimbursement for eligible expenses shall be made no later than the month following receipt of this form with appropriate receipts. Any reimbursements over the amount of $10,000 will be paid in installments.*

Send this reimbursement request and the attached itemized receipts to the address listed above

-- OVER --