

Please remember to sign your Voucher!
 For questions, please call (423) 638-7370 or 1-888-638-7370

City of Sevierville Request for Reimbursement VOUCHER (CLAIM FORM)

NAME:	Last _____ First _____ MI _____	SS#:	
ADDRESS:	Street _____ City _____ State _____ ZIP _____	DAY TIME PHONE :	() _____

Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this claim.

#1 CLAIM	MEDICAL EXPENSE CLAIM	CLAIM #1 AMOUNT
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Patient's Name	Patient's SS#	Relationship/DOB if child
Date of Service/Treatment	Reason for Expense (i.e. Office Visit, RX, Lab, dental, etc.)	
Name of Medical Provider		

#2 CLAIM	MEDICAL EXPENSE CLAIM	CLAIM #2 AMOUNT
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Patient's Name	Patient's SS#	Relationship/DOB if child
Date of Service/Treatment	Reason for Expense	
Name of Medical Provider		

#3 CLAIM	MEDICAL EXPENSE CLAIM	CLAIM #3 AMOUNT
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Patient's Name	Patient's SS#	Relationship/DOB if child
Date of Expense	Reason for Expense	
Name of Medical Provider		

#4 CLAIM	DEPENDENT CARE CLAIM	CLAIM #4 AMOUNT
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Dependent's Name	Dependent's SSN	Relationship/DOB
Beginning Date of Expense	Ending Date of Expense	Name of Child Care Provider
Child Care Provider ID #	Child Care Provider Address	

#5 CLAIM	DEPENDENT CARE CLAIM	CLAIM #5 AMOUNT
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Dependent's Name	Dependent's SSN	Relationship/DOB
Beginning Date of Expense	Ending Date of Expense	Name of Child Care Provider
Child Care Provider ID #	Child Care Provider Address	

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ **Date:** ____/____/____

FOR FASTEST REIMBURSEMENT, FAX TO [423 638-8648]

**OR MAIL TO: A. L. STORM & ASSOC., INC.
 1104 TUSCULUM BLVD. SUITE #315, GREENEVILLE, TN 37745**