



Cary Institute of Ecosystem Studies

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OPT-OUT PLAN MEDICAL EXPENSE REIMBURSEMENT REQUEST

PART I: EMPLOYEE (Complete Part I only)

Name: _____ Date: _____

Address: _____

1. Name of the individual/s for whom the medical services were performed: _____

2. Please complete the unreimbursed medical expense detail report on the reverse side of this form.
NOTE: Services qualify for reimbursement only if performed for you, your spouse, or a dependent as defined under section 152 of the Internal Revenue Code.

3. Instructions:

- a. For medical/dental expense claims that were submitted to a medical plan or an insurance company but not paid or paid in full by that carrier, attach originals or legible photocopies of other insurance carrier claims and/or payment forms (explanation of benefits forms) to establish amounts not covered under the medical/dental plan.
- b. For all other reimbursable expenses, originals or legible photocopies of all bills must be attached which show who (name and address) rendered the service, reason for charge and date and amount of charge. Receipts should be printed on provider's official receipt form or stationery and include the medical diagnosis code. Canceled checks alone are not acceptable as receipts.

4. Total amount requested for reimbursement: _____
(Insert total from unreimbursed medical expense detail report on reverse side of this form)

Only one check will be issued per month payable to the employee.

I certify that all items requested for reimbursement comply with the Cary Institute of Ecosystem Studies Opt-Out Program and such items have not and will not be covered by any other plan or program of any employer or other person. The Cary Institute of Ecosystem Studies does not accept responsibility for direct payment to any individuals other than the employee.

Employee Signature: _____ Date: _____

PART II: HUMAN RESOURCES

APPROVED: _____ NOT APPROVED: _____

SIGNATURE: _____ DATE: _____

Date of Service	Provider's Name	Patient's Name	Relationship to Employee	Type of Expense	Amount Spent	Unreimbursed Amount
TOTAL UNREIMBURSED EXPENSES						\$
TOTAL AMOUNT REQUESTED FOR REIMBURSEMENT						\$