ST. LAWRENCE-LEWIS COUNTIES SCHOOL DISTRICT EMPLOYEES MEDICAL PLAN

HRA ROLLOVER ACCOUNT
CLAIM FORM

Claim Form Instructions:

1) Copies of bills indicating date of service; provider name, patient name and charges must be enclosed with the Claim Form unless you are submitting an Explanation of benefits (EOB) statement from an insurance currier_

2) All areas of the Claim Form must be completed for any claim to be processed.

3) If you have any questions, please call the Claims Administration Office al (315) 287-2028, or write to.

St. Lawrence-Lewis
Claims Administration Office
P.O. Box 300
Richville, NY 13681

SCHOOL DISTRICT: ____________________
EMPLOYEE NAME: ____________________
EMPLOYEE ID NUMBER: ____________________
EMPLOYEE PHONE NUMBER: ____________________
EMPLOYEE ADDRESS: ____________________
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	Date(s) of Service	Amount	Description of Service	Provider of Service **Must be completed**	Claimant Name	Relationship to Employee (i.e. Self/Spouse/Child/Other-Must Specify)
❑ DENTAL ❑ VISION						
❑ DENTAL. ❑ VISION						
❑ DENTAL ❑ VISION						
❑ DENT Al. ❑ VISION						

I certify that the expenses for which reimbursement is being requested have been incurred for myself, my spouse, and/or my dependents. Any vision and/or dental expenses for which I am requesting reimbursement are expenses, which have not been reimbursed and are not reimbursable under any other health plan coverage.

______________________________ ____________

(Signature) (Date)