



MEDICAL CLAIM FORM

gente
122 Parish Drive
Wayne, NJ 07470
Gente.solutions

Employer Name: Upper Saddle River Board of Education

Employee Name: _____ SS#: X X X - X X -
Last First Last 4 Digits Only

New Address : _____

Email Address: _____

Date of Service	Service Provided	Reimbursement Amount
Total Reimbursable Expense		

Instructions:

- Complete the top portion of the form.
- List the eligible expenses:
 - Date of Service: The date the service was provided. Not the date it was billed.
 - Service Provided: Provide a brief description of the service received.
 - Reimbursement Amount: Enter the amount requested for reimbursement.
(NOTE: if you have a Health Care Explanation of Benefits to attach, enter the difference between the total expense and the amount paid).
- Sign and date your form.
- Attach the required documentation:
 - for expenses which must be submitted to an insurance company or health care plan, attach a copy of the Explanation of Benefits (EOB) form received from your insurance company.
 - for eligible medical expenses not covered by a health care plan, attach a statement of expense showing the type of service, the incurred date and the amount of expense. For example, a physician's bill or pharmacist's prescription label or itemized receipt.
Cancelled checks are not acceptable documentation.
- Send completed form and attached documentation to gente.
For Prompt Service Fax to: 973-694-2913 or email: claims@gente.solutions

I certify that the expenses listed above have been incurred by me and/or my dependent(s) and qualify for reimbursement, and that these expenses will not be claimed as a deduction on my personal income tax return. In addition the expenses listed above have not been reimbursed and are not reimbursable under any other health plan.

Your Signature

Date