

# Submitting a Reimbursement Claim Using a PDF-Fillable Form on the Benserco Website

1. Go to the Benserco/HPAE Retiree Medical Trust website - <https://www.benserconj.com/HPAE.html>
2. Click on "Medical Expense Reimbursement Form" and save the PDF file on your computer. Create your own file name – e.g. JohnDoeHPAERMT
3. Fill in the top part of the form. This is information you will always need to include.



**MEDICAL EXPENSE REIMBURSEMENT PLAN OF THE  
 HEALTH PROFESSIONALS AND ALLIED EMPLOYEES RETIREE MEDICAL TRUST**  
ADMINISTERED BY  
**BENSERCO, INC.**  
 140 SYLVAN AVENUE, SUITE 303 , ENGLEWOOD CLIFFS, NJ 07632  
 (201) 947-8000 (201) 947-9192 FAX

**MEDICAL EXPENSE OR PREMIUM REIMBURSEMENT CLAIM FORM**

NAME: <u>John Doe</u> STREET ADDRESS: <u>6 Main Street</u> CITY/STATE/ZIP: <u>Anytown, NJ 07000</u> S.S. # <u>000 - 00 - 0000</u>	IF CLAIM BY BENEFICIARY, COMPLETE FOR BENEFICIARY: NAME: _____ ADDRESS: _____ S.S. # _____ TELEPHONE # _____
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AT THE TIME I INCURRED THE EXPENSES I AM CLAIMING, I  WAS  WAS NOT EMPLOYED BY AN EMPLOYER THAT CONTRIBUTES TO THE HPAAE RETIREE MEDICAL TRUST. IF YOU WERE EMPLOYED BY A CONTRIBUTING EMPLOYER AT THE TIME THE EXPENSE WAS INCURRED, PLEASE LIST THE NAME OF THE EMPLOYER \_\_\_\_\_  
 LAST DATE WORKED \_\_\_\_\_

**INSTRUCTIONS TO SUBMIT CLAIMS FOR REIMBURSEMENT:**

1. REIMBURSEMENT WILL BE MADE DIRECTLY TO THE PARTICIPANT OR ELIGIBLE BENEFICIARY; THEY CANNOT BE ASSIGNED TO THE PROVIDER. CLAIMS ARE PROCESSED MONTHLY.
2. PLEASE SUBMIT EXPENSES COVERED BY OTHER MEDICAL AND/OR DENTAL PLANS TO THOSE PLANS FIRST.
3. EACH SUBMISSION MUST HAVE CORRESPONDING DOCUMENTATION SUCH AS AN EOB OR A RECEIPT FOR A CO-PAY OR BILLS SHOWING AMOUNT AND NATURE OF EXPENSE; PERIOD OF TIME OR DATE INCURRED COVERED BY THE BILL AND THE ADDRESS OR TAX ID OF THE SERVICE PROVIDER.
4. CLAIMS AND SUPPORTING DOCUMENTATION BECOME THE PROPERTY OF THE PLAN AND *CANNOT BE RETURNED TO YOU*. IF YOU WISH TO KEEP COPIES, PLEASE MAKE THEM BEFORE YOU SUBMIT THE CLAIM.
5. ALL EXPENSES MUST BE ITEMIZED AND ALLOWABLE UNDER THE PLAN GUIDELINES. (FOR A DEFINITION OF "COVERED EXPENSES" PLEASE REFER TO SEC. 1.6 OF THE PLAN.)

PREMIUM PERIOD OR SERVICE DATE	PROVIDED FOR	PREMIUM/EXPENSE CARRIER OR PROVIDER	TYPE OF SERVICE/COVERAGE				AMOUNT REQUESTED	ADMINISTRATOR USE ONLY
			Medical	Dental	Vision	Rx		
	NAME: SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	
	NAME: SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	
	NAME: SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	
	NAME: SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	
<b>TOTAL REQUESTED</b>							<b>\$ 0.00</b>	

SERVICE DATE: WHEN YOU OR YOUR ELIGIBLE DEPENDENT RECEIVED THE CARE OR SERVICE; PREMIUM PERIOD: MONTH(S) COVERED BY PREMIUM PAYMENT; PROVIDED FOR: WHO RECEIVED SERVICE; PROVIDER CARRIER: WHO PROVIDED THE CARE, SERVICE OR COVERAGE; TYPE OF COVERAGE OR SERVICE: PLEASE CIRCLE ONE; AMOUNT REQUESTED: CANNOT EXCEED YOUR OUT-OF-POCKET EXPENSE AFTER INSURANCE PAYMENT OR REIMBURSEMENT FROM OTHER SOURCES.

I CERTIFY THAT THE ABOVE CLAIM(S) SUBMITTED FOR REIMBURSEMENT BY ME TO THE HPAAE REIMBURSEMENT PLAN WAS INCURRED FOR SERVICES OR PREMIUMS ON BEHALF OF ME OR MY ELIGIBLE DEPENDENTS AND, TO THE EXTENT COVERED BY ANOTHER HEALTH PLAN, HAVE BEEN FIRST PROCESSED FOR PAYMENT BY THAT PLAN TO THE BEST OF MY KNOWLEDGE. I CERTIFY THAT I AM NOT ELIGIBLE FOR OR HAVE BEEN REIMBURSED FOR THE EXPENSES BY ANY OTHER ENTITY. I UNDERSTAND THAT EXPENSES REIMBURSED THROUGH THE PLAN ARE NOT ALLOWED AS DEDUCTIONS OR CREDITS WHEN FILING MY INDIVIDUAL INCOME TAX RETURN.

TYPE OF DOCUMENTATION ATTACHED: \_\_\_\_\_

_____ <small>PARTICIPANT OR BENEFICIARY SIGNATURE</small>	_____ <small>RELATIONSHIP TO RETIREE</small>	_____ <small>DATE SIGNED</small>
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PLEASE DO NOT WRITE BELOW THIS LINE; FOR ADMINISTRATION USE ONLY

NOTES: \_\_\_\_\_ CHECK # \_\_\_\_\_ ISSUED ON (DATE) \_\_\_\_\_ FOR THE AMOUNT OF \$ \_\_\_\_\_  
 CLAIM ADJUDICATED BY (INITIALS) \_\_\_\_\_ CLAIMS AUDITED AND PAID BY (INITIALS) \_\_\_\_\_

4. Save the file with this information.
5. When you want to submit a claim, open the file on your computer.

