QSEHRA Reimbursement Account
Reimbursement Request Form

Instructions: Please print or type and complete all items under **Personal Information**. In order to receive reimbursement, you must submit an *Explanation of Benefits* (if applicable) from your insurance carrier, or an itemized statement that includes the provider name, patient name, date of service, description of service, insurance responsibility (if applicable), and patient responsibility for each medical, dental or vision claim. You must sign and date this form attesting that you continue to be covered under a health insurance plan, in accordance with QSEHRA requirements, and attach any corresponding receipts in order for us to process this claim.

Personal Information	
Employer's Name Venice Christian School	**Email Address**
Employee Name	**Date of Request**
Employee Member ID Number	**Daytime Phone Number**

Health Insurance Premium Reimbursement			
Insurance Company Name	**Name of Primary Insured**	**Month/Year**	**Requested Amount**

Out-of-Pocket Health Care Expenses (Costs Not Covered by Insurance)					
Patient Name	**Relationship**	**Age**	**Date of Service**	**Type of Service (Medical, Dental, Vision)**	**Requested Amount**
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
				Total:	

In order to obtain reimbursement, please carefully read, check the boxes below and sign this form to document that you continue to have health insurance coverage.

☐ By checking this box and signing below, I attest that I continue to be covered by a health insurance plan that provides Minimum Essential Coverage (MEC) as previously documented.

☐ By checking this box and signing below, I hereby certify that the above listed expenses have not been previously reimbursed, nor are reimbursable from any other source. I hereby authorize Preferred Benefit Administrators, Inc. to obtain necessary information from all physicians, hospitals, employers and all other agents in order to adjudicate the claim for reimbursement under the Qualified Small Employer Health Reimbursement Account (QSEHRA) established by my employer.

_____ _____

Employee Signature **Date**

Send Reimbursement Requests to:
PREFERRED BENEFIT ADMINISTRATORS, INC.
P.O. Box 916188, Longwood, Florida 32791-6188

Fax: (407) 786-2999
Email: Claims@PreferredTPA.com
Toll Free: 1-888-524-2777