12/1/2013 - 11/30/2014 Warren County PBA Only Health Reimbursement Account (HRA) Co-Pay Only Reimbursement Request Form

Capital FINANCIAL GROUP, INC.

Participant First Name | MI | Last Name

Address

City | State | Zip

Email Address | Date of Birth

Social Security Number | Phone Number

Claimant Name	Date of Service	Copay Amount	Co-Pay Type and Amount to Reimburse	CFG Only
			☐ EPO Inpatient Hospital; $250 Reimbursement ☐ EPO Specialist Copay; $15 Reimbursement ☐ EPO MRA, Lab, and X-Rays; $25 Reimbursement ☐ EPO Brand Rx Copay; $5 Reimbursement ☐ EPO Non-Formulary Rx Copay; $10 Reimbursement ☐ EPO Mail Order Brand Rx Copay; $12.50 Reimbursement ☐ EPO Mail Order Non-Formulary Rx Copay; $25 Reimbursement ☐ EPO Home Health Care/Infusion Therapy; $40 Reimbursement ☐ EPO Allergy Injection; $40 Reimbursement	
			☐ EPO Inpatient Hospital; $250 Reimbursement ☐ EPO Specialist Copay; $15 Reimbursement ☐ EPO MRA, Lab, and X-Rays; $25 Reimbursement ☐ EPO Brand Rx Copay; $5 Reimbursement ☐ EPO Non-Formulary Rx Copay; $10 Reimbursement ☐ EPO Mail Order Brand Rx Copay; $12.50 Reimbursement ☐ EPO Mail Order Non-Formulary Rx Copay; $25 Reimbursement ☐ EPO Home Health Care/Infusion Therapy; $40 Reimbursement ☐ EPO Allergy Injection; $40 Reimbursement	
			☐ EPO Inpatient Hospital; $250 Reimbursement ☐ EPO Specialist Copay; $15 Reimbursement ☐ EPO MRA, Lab, and X-Rays; $25 Reimbursement ☐ EPO Brand Rx Copay; $5 Reimbursement ☐ EPO Non-Formulary Rx Copay; $10 Reimbursement ☐ EPO Mail Order Brand Rx Copay; $12.50 Reimbursement ☐ EPO Mail Order Non-Formulary Rx Copay; $25 Reimbursement ☐ EPO Home Health Care/Infusion Therapy; $40 Reimbursement ☐ EPO Allergy Injection; $40 Reimbursement	

Submit one expense per row, even if items are contained on the same receipt. Each item must be itemized and must have a corresponding receipt. If you have more than 3 receipts to submit, use additional Reimbursement Request Forms. Please DO NOT group items together or write "See Attached". Capital Financial can only process claims that are properly submitted and will deny claims that are submitted incorrectly. For each claim, attach an Explanation of Benefits (EOB) and/or an itemized bill showing: provider name, patient name, date of service, amount charged and description of services. **DO NOT SEND CREDIT CARD RECEIPTS, ORIGINAL RECEIPTS or CANCELLED CHECKS.** If covered by insurance, submit EOB or bill showing insurance payment.

Please be sure to provide your SSN.
All claims are subject to deadlines and a $10.00 check minimum as defined in your Summary Plan Description

Call Capital Financial with questions at (518) 793-2885

Mail to: Capital Financial Group, Inc.
89 Saratoga Avenue
South Glens Falls, NY 12803

Fax to: (855) 220-9669

By submitting this form to Capital Financial Group, Inc., I certify that the information herein is true and correct, that the expenses incurred were for myself, spouse or qualified dependents and that these expenses are not reimbursable under any other plan coverage (i.e., spouse's insurance)

Signed _____