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Cooper County Government

Reimbursable Deductible Allowance Claim Form

⇒ PART I COMPLETE FOR ALL REIMBURSABLE DEDUCTIBLE ALLOWANCE
(TO BE COMPLETED BY EMPLOYEE ONLY)

Employee's Name: _____

Social Security#: _____ Date of Birth: _____/_____/_____

Home Address: _____
(Number) (Street/Apt#) (City) (State) (Zip)

⇒ PART II COMPLETE FOR DEPENDENT REIMBURSABLE DEDUCTIBLE ALLOWANCE

Dependent's Name: _____ Date of Birth: ____/____/____ ☐Male ☐Female

Relationship: ☐Spouse ☐Son ☐Daughter ☐Other: _____

⇒ PART III COMPLETE FOR ALL REIMBURSABLE DEDUCTIBLE CLAIMS

Date of Service: _____ Amount of Claim: $_____

Physician / Hospital / Facility name where services were rendered: _____

_____

_____

***Please Attach a Copy of the Paid Claim(s) with a Paid Receipt(s) ***

I/We certify that the above information is true and correct. I/We authorize the release of any medical or other information necessary to evaluate and complete the review and processing of any claims for reimbursement. A photocopy of this authorization shall be considered as valid as the original.

Signature of Employee: _____ **Date**: _____

Signature of Spouse (if patient): _____ **Date**: _____