REIMBURSEMENT FORM

Name of Employer: _____

Participant Name: _____

Participant Address: _____

Participant ID Number : _____

Attach itemized bill and receipts to claim form for medical expenses.

	Patient Name	Date of Birth	Date(s) of Service	Provider (Person or Business)	Charge Amount
1					
2					
3					
4					
5					
6					

I hereby certify that the information given on this reimbursement form is complete and accurate.

_____ ____/____/____

(Signature) (Date)

KEEP A COPY FOR YOUR FILES

Submit to:

Apta

PO Box 70

Arnold, MD 21012