Contact Information:
Point C
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SUPPLEMENTAL HEALTHCARE BENEFIT ACCOUNT CLAIM FORM

NOTE:	**You must submit an Explanation of Benefits (EOB) or itemized statement showing your cost share with your claim form to Point C for reimbursement.**

Tribe		
Last name	**First name**	**Roll Number**
Address ☐ Check box if this is a new address		
City	**State**	**Zip**
Email	**Phone**	☐ Check if Point C Benefits Card was Used

All requested information on this form must be provided along with a copy of your EOB or itemized statement.
Incomplete forms will not be processed.

	Expense # 1	Expense # 2	Expense # 3	Expense # 4	Expense # 5
Date of Service					
Name and Relationship of Person Receiving Medical Service	**Name:** ☐ **Self** ☐ **Spouse** ☐ **Dependent**	**Name:** ☐ **Self** ☐ **Spouse** ☐ **Dependent**	**Name:** ☐ **Self** ☐ **Spouse** ☐ **Dependent**	**Name:** ☐ **Self** ☐ **Spouse** ☐ **Dependent**	**Name:** ☐ **Self** ☐ **Spouse** ☐ **Dependent**
Type of Service Provided					
			☐ ☐		
EOB/RX Proof Attached	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
Amount Paid					
Reimbursement Requested Amount					
				Total Reimbursement Requested	

I authorize the above expenses to be reimbursed from my Supplemental Healthcare Benefit Account. To the best of my knowledge, my statements on this Form are true and complete. I certify all the following: Either I, my Spouse or my Dependent has received the services described above on the dates indicated, or the expenses qualify as valid Medical Care Expenses under Code Section 213(d). I certify that all drugs were obtained legally in the United States. These expenses have not previously been submitted for reimbursement under the Plan. They have not been reimbursed under this Plan or any other plan, and I will not seek reimbursement for them under any other health plan. These expenses are for medical care excluding cosmetic purposes, are not incurred for general health purposes, and do not constitute toiletries. I understand that the expenses reimbursed may not be used to claim any federal income tax deduction or credit. I also understand that I may be asked to provide further details about some expenses (*e.g. a statement from a medical practitioner that the expense is to treat a specific medical condition or a more detailed certification from me*).

Tribal Citizen Signature: _____ **Date:** _____
*(Signature **must** be provided in order to process this form)*

This plan is governed by IRS guidelines. To satisfy IRS requirements documentation is needed to process your claim(s). When submitting for reimbursement, please complete and provide necessary documentation. This will quicken the processing time of your claim(s). Please visit our website https://pointc.wealthcareportal.com/Page/Home*for additional forms.*