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# Adair County Government Reimbursable Deductible Allowance Claim Form

⇒ **PART I COMPLETE FOR ALL REIMBURSABLE DEDUCTIBLE ALLOWANCE**

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: \_\_\_\_\_

NOTICE: The information contained on this claim form, may be legally privileged and/or confidential protected health information. This information is intended only for use of the individual(s) and/or entity identified above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to protect the information after its stated need has been fulfilled. If you are not the intended recipient, or an employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any disclosure, printing, copying, forwarding, or distributing of this information is strictly prohibited. If you have received this in error, please notify the sender immediately, by telephone or fax, to advise of wrongful receipt and confirm your understanding of this Notice. Thank You.