## Employer Name

Employee Information		Expenses to be Reimbursed	Expenses to be Reimbursed	
Name (Last, First, Middle Initial)				
		Type of Expense Date Incurred	d Amount	
Address (Street)				
		Tota	0	
Employee Email Address			'	
Names of Dependent	0			
Dependent Name DC	8 Belationship	Tota	0	
	8 8 8			
	8 8 8	Tota	0	
	8 8 8	Tota	0	
Employee Signature				
Please Note: ! "#\$\$	8		0	
	nyh:	art	<u> </u>	
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## Instructions for Filing a Claim

For medical/dental/vision expense claims that were submitted to a health plan or an insurance company but were not f