

Medical Expense Claim Form

Fax: 559-241-7395

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To make a claim for reimbursement of your medical, dental and vision expenses, please complete this form and attach copies of the Explanation of Benefits from your insurer or copies of the imprinted, personalized and detailed bills prepared by your care providers. Charge card or cash register receipts must show detailed information on the services received or items purchased. Detailed pharmacy bills including the name of the medication are required for non-standard co-payment amounts.

Mail your claim and documentation to:

Hicks Pension Services
3459 W. Shaw Ave.
Fresno, CA 93711

Check here if address has changed

Required	Employer/Plan Sponsor	
	ALBIN ENGINEERING	
	Your Name	
	Address	
	City, State and Zip Code	
	Email Address	
Social Security Number	Phone Number	
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Additional Comments:	Plan Year:	

PLEASE READ AND SIGN BELOW

I hereby understand, certify and agree that: The expenses submitted for reimbursement have not been reimbursed or paid previously and I will not seek payment or reimbursement under insurance or other benefit plan for these expenses; These expenses were incurred during the coverage period by either me or eligible dependents; I assume the responsibility to maintain substantiating documents for all claims; I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim; I am liable for payment of any taxes and penalties, federal, state or local, related to expenses claimed or paid that are not eligible expenses under the Plan(s); These expenses cannot be claimed as credits or deductions on my personal tax return if reimbursed or paid from the Plan(s); Any medically related expenses submitted are to diagnose, alleviate or prevent a medical condition and not merely beneficial to general health; If my spouse or I make or receive contributions to a Health Savings Account (HSA), my benefits are considered Limited Purpose and I will only submit claims for qualifying expenses related to preventive care, vision care, dental care and/or post deductible expenses; I have received a copy of the Summary Plan Description(s) and understand that this claim is subject to the terms and requirements of the Plan(s), including but not limited to eligibility, coverage period and claims filing deadlines; I may receive notifications by email instead of mail and I understand that I must notify Hicks Pension Services in writing to rescind this authorization to send notifications by email; and, My signature on this form will be accepted as binding.

Signature	Date
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Total Medical Expenses Claimed With This Request: \$ _____

Name of Person Receiving Care	Relationship to Employee	Date Services Provided	Name of Care Provider	Type of Service	This is my Cost for this Service
					\$
					\$
					\$
					\$
					\$
					\$
					\$
					\$
					\$

Hicks Pension Services • 3459 W Shaw Ave • Fresno, CA 93711 • Ph: 559-241-7390 or 800-366-7887 • Fax 559-241-7395 • Email ss@hicksfresno.com

You can send claims to us by fax, mail or electronically. A claim form is required and must be signed and dated in order for your claim to be processed; if the claim form is not received and/or signed it will be returned. If you are going to electronically send or scan your claims, please be sure the documentation is clear and legible. Terminated Employees can submit a voucher for a specified period after the date of termination if so stated in the Summary Plan Description. Date of service must have occurred before termination date. **If a plan year is not indicated on the form, we will assume that the expense is for the current plan year.**