



ClaimLinx
 10260 Alliance Road
 Suite 325
 Cincinnati, OH 45242
 Phone (800) 858-1772 or (513) 677-6262
 Fax (800) 858-1913 or (513) 677-6263
 help@claimlinx.com
 www.claimlinx.com

Medical/Dental Expense Reimbursement Claim Form

NOTE: Please fax or mail and attach a copy of your receipt(s) to process your request.

Today's Date: _____ # Pages _____
(include coversheet)

Company: _____

Employee Name: _____
(Please Print Clearly – First Name, MI, Last Name)

Relationship: **S = Self / SP = Spouse / CH = Child**
 Type of Service: **OV = Office Visit, UC = Urgent Care, DV = Dental Visit**

	Name	Relationship to Employee (circle)	Type of Service (Circle)	Employee Paid Amount	Reimbursement Amount
1		S / SP / CH	OV / UC / DV		
2		S / SP / CH	OV / UC / DV		
3		S / SP / CH	OV / UC / DV		
4		S / SP / CH	OV / UC / DV		
5		S / SP / CH	OV / UC / DV		
6		S / SP / CH	OV / UC / DV		
7		S / SP / CH	OV / UC / DV		
8		S / SP / CH	OV / UC / DV		
9		S / SP / CH	OV / UC / DV		
	TOTAL				\$

****CONTACT OUR OFFICE IF YOU HAVE ANY QUESTIONS****
 help@claimlinx.com | (800) 858-1772