ClaimLinx
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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