

ECU Human Resources, Supplemental Fringe Benefits Office

210 East 1st Street, Bldg. 127, Greenville, NC 27858

Supplemental Health Expense Reimbursement Plan Agreement (SHERPA) & **Dental Reimbursement Claim Form**

SHERPA Claims Amount Eligible for Date of Amount of Payment Under Amount Eligible for Medical Provider Service Expense Other Benefit Plans* Reimbursement TOTAL: *Include amounts paid or eligible for payment under any other health care plan or program, federal, state, or governmental program, workers' compensation, or any other policy of health insurance. For all SHERPA claim submissions, please include with your claim the bill from the provider's office, the explanatio benefits from insurance, and proof of payment for the out-of-pocket expenses for each of the services listed above Dental Claims Amount Eligible for	Insured/Employee's Name				
Medical Provider Date of Amount of Payment Under Amount Eligible for Payment Under Amount Payment Under Amount Eligible for Payment Index For all SHERPA claim submissions, please include with your claim the bill from the provider's office, the explanation benefits from insurance, and proof of payment for the out-of-pocket expenses for each of the services listed above Dental Claims Date of Amount of Payment Under Amount Eligible for Payment Eligible f	Relationship to Insured				
Medical Provider Service Expense Other Benefit Plans* Reimbursement TOTAL: *Include amounts paid or eligible for payment under any other health care plan or program, federal, state, or governmental program, workers' compensation, or any other policy of health insurance. For all SHERPA claim submissions, please include with your claim the bill from the provider's office, the explanation benefits from insurance, and proof of payment for the out-of-pocket expenses for each of the services listed above. Dental Claims Amount Eligible for Payment Under Amount Eligible for Payment Under Amount Eligible for Other Benefit Plans* Reimbursement TOTAL: *Include amounts paid or eligible for payment under any other health care plan or program, federal, state, or governmental program, workers' compensation, or any other policy of health insurance. For all dental claim submissions, please include with your claim the bill from the provider's office listing services received, the explanation of benefits from the dental insurance company (if enrolled), and proof of payment for the out-of-pocket expenses for each of the services listed above. Important Notice: Services paid with Healthcare Flexible Spending Account funds are ineligible for reimbursement. A person may be committing insurance fraud if he or she submits a claim containing a false or deceptive statement with intent to defraud an insurance company. I certify the information provided above is correct. If any changes occur after submission of a claim, it is my	SHERPA Claims			Amount Eligible for	
Include amounts paid or eligible for payment under any other health care plan or program, federal, state, or governmental program, workers' compensation, or any other policy of health insurance. For all SHERPA claim submissions, please include with your claim the bill from the provider's office, the explanation benefits from insurance, and proof of payment for the out-of-pocket expenses for each of the services listed above. Dental Claims Date of Amount of Payment Under Amount Eligible for Dental Office Service Expense Other Benefit Plans Reimbursement *Include amounts paid or eligible for payment under any other health care plan or program, federal, state, or governmental program, workers' compensation, or any other policy of health insurance. For all dental claim submissions, please include with your claim the bill from the provider's office listing services received, the explanation of benefits from the dental insurance company (if enrolled), and proof of payment for the out-of-pocket expenses for each of the services listed above. Important Notice: Services paid with Healthcare Flexible Spending Account funds are ineligible for reimbursement. A person may be committing insurance fraud if he or she submits a claim containing a false or deceptive statement with intent to defraud an insurance company. Il certify the information provided above is correct. If any changes occur after submission of a claim, it is my	Medical Provider			•	Amount Eligible for Reimbursement
Include amounts paid or eligible for payment under any other health care plan or program, federal, state, or governmental program, workers' compensation, or any other policy of health insurance. For all SHERPA claim submissions, please include with your claim the bill from the provider's office, the explanation benefits from insurance, and proof of payment for the out-of-pocket expenses for each of the services listed above. Dental Claims Amount Eligible for Payment Under Amount Eligible for Dental Office Service Expense Other Benefit Plans Reimbursement *Include amounts paid or eligible for payment under any other health care plan or program, federal, state, or governmental program, workers' compensation, or any other policy of health insurance. For all dental claim submissions, please include with your claim the bill from the provider's office listing services received, the explanation of benefits from the dental insurance company (if enrolled), and proof of payment for the out-of-pocket expenses for each of the services listed above. Important Notice: Services paid with Healthcare Flexible Spending Account funds are ineligible for reimbursement. A person may be committing insurance fraud if he or she submits a claim containing a false or deceptive statement with intent to defraud an insurance company. Certify the information provided above is correct. If any changes occur after submission of a claim, it is my					
Dental Claims Date of Amount of Payment Under Amount Eligible for Payment Under Amount Eligible for Payment Under Amount Eligible for Reimbursement Plans* TOTAL: *Include amounts paid or eligible for payment under any other health care plan or program, federal, state, or governmental program, workers' compensation, or any other policy of health insurance. For all dental claim submissions, please include with your claim the bill from the provider's office listing services received, the explanation of benefits from the dental insurance company (if enrolled), and proof of payment for the pout-of-pocket expenses for each of the services listed above. Important Notice: Services paid with Healthcare Flexible Spending Account funds are ineligible for reimbursement. A person may be committing insurance fraud if he or she submits a claim containing a false or deceptive statement with intent to defraud an insurance company. Lecrtify the information provided above is correct. If any changes occur after submission of a claim, it is my	governmental program, workers' of all SHERPA claim submissions,	compensation, or a	ny other policy o	of health insurance. e bill from the provider's	office, the explanation
Date of Service Expense Other Benefit Plans* Reimbursement FOTAL: *Include amounts paid or eligible for payment under any other health care plan or program, federal, state, or governmental program, workers' compensation, or any other policy of health insurance. For all dental claim submissions, please include with your claim the bill from the provider's office listing services received, the explanation of benefits from the dental insurance company (if enrolled), and proof of payment for the put-of-pocket expenses for each of the services listed above. Important Notice: Services paid with Healthcare Flexible Spending Account funds are ineligible for reimbursement. A person may be committing insurance fraud if he or she submits a claim containing a false or deceptive statement with intent to defraud an insurance company. Certify the information provided above is correct. If any changes occur after submission of a claim, it is my			ne out-or-pocke	•	services listed above.
*Include amounts paid or eligible for payment under any other health care plan or program, federal, state, or governmental program, workers' compensation, or any other policy of health insurance. For all dental claim submissions, please include with your claim the bill from the provider's office listing services received, the explanation of benefits from the dental insurance company (if enrolled), and proof of payment for the out-of-pocket expenses for each of the services listed above. Important Notice: Services paid with Healthcare Flexible Spending Account funds are ineligible for reimbursement. A person may be committing insurance fraud if he or she submits a claim containing a false or deceptive statement with intent to defraud an insurance company. I certify the information provided above is correct. If any changes occur after submission of a claim, it is my	Dental Office			Payment Under	Amount Eligible for Reimbursement
governmental program, workers' compensation, or any other policy of health insurance. For all dental claim submissions, please include with your claim the bill from the provider's office listing services received, the explanation of benefits from the dental insurance company (if enrolled), and proof of payment for the out-of-pocket expenses for each of the services listed above. Important Notice: Services paid with Healthcare Flexible Spending Account funds are ineligible for reimbursement. A person may be committing insurance fraud if he or she submits a claim containing a false or deceptive statement with intent to defraud an insurance company. I certify the information provided above is correct. If any changes occur after submission of a claim, it is my	TOTAL:				
received, the explanation of benefits from the dental insurance company (if enrolled), and proof of payment for the out-of-pocket expenses for each of the services listed above. Important Notice: Services paid with Healthcare Flexible Spending Account funds are ineligible for reimbursement. A person may be committing insurance fraud if he or she submits a claim containing a false or deceptive statement with intent to defraud an insurance company. I certify the information provided above is correct. If any changes occur after submission of a claim, it is my	, -		•		deral, state, or
person may be committing insurance fraud if he or she submits a claim containing a false or deceptive statement wit intent to defraud an insurance company. I certify the information provided above is correct. If any changes occur after submission of a claim, it is my	received, the explanation of bene	fits from the denta	l insurance com		_
	person may be committing insurar	nce fraud if he or sh		_	
					laim, it is my