










## INSTRUCTIONS FOR COMPLETING THE CLAIM REIMBURSEMENT FORM

1. Please complete your claim form as follows:
2. Medical Expenses
  -  Date the service was provided
  -  Name of the service provider
  -  A brief description of the procedure or expense
  -  Name of the person for whom the service was provided
  -  Amount claimed for reimbursement
  -  If you wish to allow EBSC to share information pertaining to this claim with individuals other than yourself (in case we need to explain what information is needed to help you get reimbursement for these expenses), you must designate an Authorized Representative on the form
  -  Attach a copy of the insurance company's EOB and/or third party receipts for the expenditures for reimbursement of any expenses
3. Read the statement regarding submitting your claim, located above the signature line. Sign and date the form.
4. When submitting a claim, include the **ORIGINAL** bill or receipt (when available) **and** EOB (Explanation of Benefits, from your insurance carrier) with your reimbursement claim form. Make a copy of the bill, receipt and EOB for your records. Submit the claim (using one of the following methods) to:

**Mail:**

EBSC  
Fringe Department  
940 Industrial Drive South  
Suite 111  
Sauk Rapids, MN 56379

**E-mail:**

[Claims@EBSC-online.org](mailto:Claims@EBSC-online.org)

**Fax:**

(320) 257-8127  
Or  
(800) 889-3057

5. **The Employee is the only person eligible to sign the Reimbursement Claim Form!**

**We cannot pay a claim without all of the above information.**

**If there is any other reason why we cannot make reimbursement to you, we will notify you in writing and you may resubmit the claim for reimbursement with the proper documentation.**