



www.myebsaccount.com to submit claims on-line

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Name	Relationship To Employee SELF, SPOUSE, CHILD OTHER (SPECIFY)	Amount	Date(s) Of Service	Description Of Service	CLAIM REF #	OFFICE USE ONLY
					01	
					02	
					03	
					04	
					05	
					06	
					07	
					08	
					09	
					10	

IMPORTANT: SIGNATURE REQUIRED BELOW

EMPLOYEE SIGNATURE:

INSTRUCTIONS

1. If you are submitting expenses eligible under another insurance plan, you **must** submit an Explanation of Benefits (EOB) statement.
2. Copies of **all bills (and EOB if required)** for reimbursement must be enclosed with this completed reimbursement form.

Bills must include:

- Name of person providing the service
- Dates of service
- Description of the service(s) rendered
- The amount charged
- The name of person receiving services

Balance bills, canceled checks, etc. are **not** acceptable.

3. All claims must be received at least 5 business days prior to your scheduled reimbursement date.

If you have any questions, please call our Customer Service Department at: 1-800-327-7130. Visit us on the web at www.myebaccount.com

SEND COMPLETED CLAIM FORM TO:

Mail: EBS Benefit Solutions, Inc.
PO Box 22999
Rochester, NY 14692

Fax: 1-877-256-7228

Please note: Faxing or mailing your claim may increase processing time. For faster processing time, submit your claim on our website at www.myebaccount.com.