EBA&M Corporation
18002 Cowan
Irvine, CA 92614
Attn: Debit Card Reimbursement
Fax: (714) 437-1142

MaxMed105 Debit Card *REQUEST FORM*

This form is to be used when you were unable to use your Benny Card for your medical expense and you need to be manually reimbursed. DO NOT USE THIS FORM TO SUBSTANTIATE CHARGES ON YOUR BENNY CARD.

EMPLOYER NAME

EMPLOYEE NAME (LAST, FIRST):	**DAYTIME TELEPHONE #:**

Please list out the itemized receipts that are attached.		
Date of Service	**Type: (Medical)**	**Amount**

SUPPORTING DOCUMENTATION MUST BE ATTACHED TO VALIDATE ALL REIMBURSEMENT SUBMISSIONS. DOCUMENTATION MUST BE A COPY OF YOUR EXPLANATION OF BENEFITS (EOB) FROM YOUR CARRIER. THE TAX IDENTIFICATION NUMBER OR SSN OF THE PROVIDER SHOULD BE INCLUDED ON THIS FORM FOR EACH EOB.

I hereby certify that the information reported on this form is correct and that I have not previously received reimbursement for these charges from this or any other plan of coverage. I understand that these expenses may not be claimed for credit or deduction on my personal income tax return. I also understand that any reimbursement will be issued to the provider listed on the attached Explanation of Benefits (EOB) unless indicated otherwise on this form. I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

EMPLOYEE SIGNATURE	**DATE**