HEALTH REIMBURSEMENT REQUEST

PART 1. Tribal Member Information (Cardholder) (Please Print)

NAME (Last & First)	DATE OF BIRTH	SOCIAL SECURITY NO. (OPTIONAL)
ADDRESS Number Street City State Zip Code		TELEPHONE NO. AREA CODE NUMBER
GROUP NAME: Miami Nation Limited Health Benefit Plan	TRIBAL MEMBERSHIP ENROLLMENT NUMBER:	

DESCRIPTION OF ELIGIBLE EXPENSES

(Please list Each Expense on a Separate Line)

PART 2. Eligible Expenses

PATIENT'S FULL NAME	BIRTHDATE	DATES OF SERVICE FROM	DATES OF SERVICE TO	WITHDRAWAL REQUEST AMOUNT
			TOTAL	$

MEMBER'S CERTIFICATION FOR REIMBURSEMENT

I certify that all expenses claimed above for reimbursement from my Miami Nation Limited Health Benefit Plan were incurred by me, have been paid by me and were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Miami Nation Limited Health Benefit Plan. I understand that the expenses reimbursed through this Plan cannot be used as deductions or credits when filing my individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive Miami Nation Limited Health Benefit Plan, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Member Signature: _____ **Date:** _____

(If member is a minor child under 18, parent's signature is required below)

Parent's Signature _____ **Date** _____

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Instructions:

Please read these instructions before completing the Withdrawal Request attached to this form.

1. Complete all areas of Part 1 “Member Information”.
2. Complete Part 2 “Eligible Expenses”.

   a. **Attaching Documentation . . .**
   When you submit your request for reimbursement, you **must** include itemized statement for the services or an Explanation of Benefits. For Over the Counter Items please include the name of the item purchased.

3. Read the Member’s Certification for Reimbursement statement, then sign and date the form where indicated.
4. There are four ways to submit your claim(s) to HealthSmart:

   a) Self Service Portal: https://healthsmart.wealthcareportal.com and login to the member’s portal site. In order to submit your claim via HealthSmart’s secure portal site, you will need your Tribal ID number. If you do not have your User ID and password, contact Customer Service: 844.516.3658
   b) Mobile application: HealthSmart My Flex Spending
   c) Fax: 844.319.3669
   d) US Mail: P.O. Box 16647, Lubbock, TX 79490-6647