



**HEALTH CARE REIMBURSEMENT ACCOUNT REQUEST**  
**CENTRAL NEW MEXICO COMMUNITY COLLEGE**  
 Return to: The Cafeteria Plan Company  
 Fax 505-247-0568; email [dwright@rsabq.com](mailto:dwright@rsabq.com)  
 500 Fourth St. NW, Albuquerque NM 87102  
 Phone: 505-822-9300

<b>Employee Name:</b>	<b>Employee ID:</b>
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**Employee Address:**

**City, State and Zip:**

*You may submit a reimbursement request only for yourself and/or your taxable dependents.*

**INSTRUCTIONS**

*Please note the following administrative guidelines to ensure timely processing of your claim:*

- This request form must be *completed and signed and accompany your claim*
- All receipts be readable. Originals are not required. You may fax copies, or scan and email your receipts with an accompanying claim form.
- All receipts must show: the *date & type of service and provider information*
- Claims reimbursed through this plan cannot be used on my personal income taxes
- I understand the service(s) for which I am requesting reimbursement must be incurred during the current Plan Year, or within the 2.5 month grace period following the end of the plan year.
- The following itemization summarized the documents/receipts that are attached.

Date(s) of Service	Type of Service	Service Provider	Dollar Amount
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____

Claim Total: \$ \_\_\_\_\_

I request reimbursement for the attached receipts under the Medical Reimbursement Plan. I certify that I or my eligible dependents have incurred these expenses. Furthermore, I declare that these expenses have not been reimbursed from any other source nor do I expect them to be. I certify that these expenses are for medical expenses as defined by Section 213 of the Internal Revenue Code.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_