

# WEBER COUNTY MEDICAL REIMBURSEMENT REQUEST FORM

Employee's Name: \_\_\_\_\_ ID # \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

**Instructions:** Complete the following information below for medical/dental expenses incurred by you, your spouse or other eligible dependents and for which you request reimbursement. Please attach receipts or other evidence that the expenses were incurred. Send this form along with your supporting receipts to Personnel by the 20<sup>th</sup> of the month.

	Expense #1	Expense #2	Expense #3	Expense #4	Expense #5
Date Medical Service Actually Provided					
Name of Person Receiving Medical Service and Relation to you	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent				
Type of Service					
Total Expense	\$	\$	\$	\$	\$

**Reimbursement Requested This Page** \$ \_\_\_\_\_

**TOTAL REIMBURSEMENT ALL PAGES** \$ \_\_\_\_\_

I certify these expenses are valid medical/dental services on the dates indicated, and have not been and are not reasonably expected to be reimbursed under this or any other health plan. I understand that these expenses may not be used to claim any Federal income tax deduction or credit.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date