

# OUT OF POCKET EXPENSE REIMBURSEMENT CLAIM FORM INSURE OKLAHOMA

## Instructions

- 1) **Please PRINT or TYPE.** Use only **BLUE** or **BLACK** ink to complete this form. Failure to provide complete, accurate information will result in a non-paid expense(s). Remember to keep the originals and make copies of the documents you are submitting for your own records. **DO NOT** group expenses, each expense **MUST** be listed individually.

For additional assistance or information, call our helpline at **1-888-365-3742** or visit our website at [www.insureoklahoma.org](http://www.insureoklahoma.org). For the hearing impaired, call **(405) 416-6848** (TDD/TTY).

- 2) You **MUST** attach **ALL PAGES** of documentation depending on what program you are enrolled in (Employer Sponsored Insurance - Explanation of Benefits (EOB) or Individual Plan - paid receipts) for each expense listed below. For pharmacy expenses a cash register receipt **MUST** be accompanied by the pharmacy tag receipt or a pharmacy printout showing insurance information.
- 3) A health expense must be for an allowed and covered service by a qualified benefit plan (QBP) to be eligible for reimbursement. (See OAC 317:45-1-4 Reimbursement for out of pocket medical expenses)
- 4) All claim forms must be received by March 31<sup>st</sup> for any expenses from the previous year.
- 5) **Mail to:** Insure Oklahoma, P.O. Box 54200, Oklahoma City, OK 73154-1200  
**Fax to:** (405) 530-3433  
**E-mail to:** insureok@okhca.org

<b><u>Applicant Information</u></b>			
Name: Last: _____	First: _____	M.I.: _____	
SSN: _____ - _____ - _____	Daytime Phone Number: (_____) _____		
Address: _____	City: _____	State: _____	
Employer Name: _____			

**List only the in-network expenses incurred by the applicant and eligible Insure Oklahoma household member(s).**  
*(Attach additional page if necessary)*

Date of Services (mm/dd/yyyy)	Person for Whom Expense Was Incurred		Expense Description (Medicine, Provider, Facility)	Expense Amount
	Name (Last, First, M.I.)	Social Security Number		
<b>Total Requested</b>				<b>\$</b>

The information I give on this form is true and correct to the best of my knowledge. I realize if I give information that is not true OR if I withhold information, I can be lawfully punished for fraud or perjury. I may also have to re-pay the State of Oklahoma for any payments or claims incurred which were paid due to my fraud or error. (28 USC 1746)

**Signature:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_