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.** 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 medical expense must be for an allowed and covered service by a qualified health plan (QHP) 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 no later than 90 days after the end of the applicant's eligibility period.

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**

Applicant Information

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		
			Total Requested	**$**

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:** _____