MEDICAL CO-PAY REIMBURSEMENT

Kaleida Health

Employee Name: _____ Employee ID #: _____ Employee Phone #: (___) _____

Submit requests along with receipts by:

* **mail**: Kaleida Health – Corporate Benefits
100 High Street, Mailbox 209
Buffalo, NY 14203

* **fax**: (716) 859-8671

* **scan/email**: KaleidaBenefitsEnrollment@KaleidaHealth.org

Service Entries:

Date of Service	Patient's Name	Relationship to Employee	Provider Name	Refund Amount * please see contract for allowable amount

Receipts must be attached to reimbursement request and include the following: ***Total: $ _____***

- **Patient's Name**
- **Provider's Name**
- **Date of Service**
- **Amount Paid**

_____ _____

Employee Signature **Date**

FOR OFFICE USE ONLY:

INITIALS/DATE:_____ DATE STAMP:
NOTES: