



Marple Newtown School District

Inpatient Hospital Copayment/Outpatient Surgery Copayment Reimbursement Claim Form

Please Mail or Fax to:
 Brokerage Professionals
 40 West Front Street
 Media, PA 19063

Tel: 610-566-4920
 Fax: 610-627-0256

Employee's Name	Social Security Number										
<div style="display: flex; justify-content: space-between; font-size: small;"> LAST FIRST MIDDLE </div>	<table border="1" style="width: 100%; text-align: center; border-collapse: collapse;"> <tr> <td style="width: 12.5%;">X</td> <td style="width: 12.5%;">X</td> <td style="width: 12.5%;">X</td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;">X</td> <td style="width: 12.5%;">X</td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>	X	X	X		X	X				
X	X	X		X	X						
Employee's Street Address	City, State, Zip										
Dependent's Full Name (claimant)	Social Security Number										
<div style="display: flex; justify-content: space-between; font-size: small;"> LAST FIRST MIDDLE </div>	<table border="1" style="width: 100%; text-align: center; border-collapse: collapse;"> <tr> <td style="width: 12.5%;">X</td> <td style="width: 12.5%;">X</td> <td style="width: 12.5%;">X</td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;">X</td> <td style="width: 12.5%;">X</td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>	X	X	X		X	X				
X	X	X		X	X						

REIMBURSABLE EXPENSES CHART ⁽¹⁾

Description of Reimbursable Expense	In Network	Out of Network
Inpatient Hospital Copayment	\$150 Per Day Copayment	N/A
Outpatient Hospital Surgery Copayment	\$150 Copayment	N/A

(1) You Must Attach your Hospital Invoice and Explanation of Benefits from Blue Cross

Dates of Service	Provider's Name	Provider's Federal ID NO.	Description of Reimbursement Request <i>(See chart above)</i>	Requested Reimbursement Amount
FROM TO				

Marple Newtown Inpatient Hospital Copayment and Outpatient Hospital Surgery Copayment Claim Certification

I certify that Reimbursement Claim expenses have been incurred and paid by me, my spouse, or dependent(s), and have not or will not be reimbursed from any other source and have not or will not be used by me, my spouse or my dependent(s) as deductions in filing income tax returns.

Signature _____

Date _____