CAPROCK
HEALTHPLANS
A Division of Caprock Health Group

MEDICAL EXPENSE REIMBURSEMENT PLAN (MERP)
CLAIM FORM

Please complete all sections below and mail to Caprock HealthPlans at address below.

EMPLOYEE INFORMATION	
Employee Name:	Employee Social Security #:
Employee Address:	City/State/Zip:
Daytime Phone #:	Email:

PATIENT INFORMATION	
An Explanation of Benefits must be submitted with every MERP claim reimbursement request.	
Patient Name:	Patient Date of Birth:
Patient Relationship to Employee:	Does Patient have any other insurance? Yes or No

EMPLOYEE CERTIFICATION FOR REIMBURSEMENT	
I certify that the expenses being submitted for reimbursement were incurred by me, my spouse or by one of my eligible dependents. These charges were not reimbursed and are not eligible to be reimbursed by any other plan. To the best of my knowledge, I believe these charges are eligible for reimbursement under my Medical Expense Reimbursement Plan. I understand any reimbursements received through this plan/account can not be used when filing my income tax return. I understand any reimbursement being made is done so in accordance with the provisions of the plan. I accept responsibility for the proper treatment of benefits paid under this plan with respect to eligiblity, income tax reporting, and liability.	
Employee Signature:	Date:

MAIL CLAIM FORM TO:

CAPROCK HEALTHPLANS
320 S POLK ST STE 900
AMARILLO, TX 79101