



# Technical Education Association Out-of-Pocket Reimbursement Claim

\*VTA Contract Only

## Employee Information

Employee's Name		Date
Employee Number	Date of Birth	Employee Phone Number
Employee's Home Address		
City	State	Zip Code

## Medical Provider/Service Information

Provider Name		Date of Service
Provider's Address		
City	State	Zip Code
Total Out-of-Pocket Cost		

## Additional Information and Instructions:

A copy of your receipts and/or a copy of your Explanation of Benefits must be attached to this form in order for the claim to be processed. Failure to provide all required information may delay your reimbursement payment. Benefits will be paid directly to the employee only. No exceptions.

Reimbursement year runs July 1st through June 30th. Plan is administered on a "first come, first served" basis with an annual maximum "pool" of \$1,725.00. Reimbursement excludes office visit co-pays. For additional information contact Benefits at 610-938-9000 ext. 2003.

Please submit claim form to:

Delaware County Intermediate Unit  
Attention: Medical Reimbursement Claim- Business Office  
200 Yale Avenue  
Morton, PA 19070

**\*\*\*DO NOT FAX CLAIM FORM\*\*\***

I hereby agree by signing this authorization that any payment made in accordance with the benefit amount of this plan shall constitute a complete release of the Delaware County Intermediate Unit (DCIU) of all liability to the extent of such payment and that I am financially responsible for charges not covered by this authorization or in excess of the benefits provided by this plan.

Employee Signature	Date
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## FOR OFFICE USE ONLY

Amount Available	Amount Approved	Date Approved
Authorized By	Date	