Print Form

Medical Claim form

CAS
Consolidated Admin Services
P.O. Box 1513
Cabot, AR 72023
Phone: 501-941-5956
Fax: 877-641-5956
info@consolidatedadmin.com
www.consolidatedadmin.com

Date

Employer

SSN

First Name

Last Name:

Address:

☐ Check here if new address

Documentation/Receipts for each expense must be provided.

Please Itemize each expense on form provided, if you have more expenses than form allows please attach separate form.

Date of Service	Provider Name	Description of Service	Expense Amount

Total Expense

I certify that the statement and information on this claim form are accurate and true.
I also certify that I am claiming reimbursement for only eligible expenses incurred during the plan year and are for eligible participants.
I certify that these expenses have not been or will not be reimbursed from any other source.
I assume all liability for taxes and penalties out of any disallowed contribution/reimbursement

Signature:

Date:

Mail claims to: P.O. Box 1513, Cabot AR 72023; Fax claims to: 877-641-5956; or E-mail claims to: info@consolidatedadmin.com
For questions regarding your claims please call: 501-941-5956