Request for Supplemental Reimbursement for Mental Health Care Services

Instructions: Please complete all sections of the following form. Attach the **original** paid receipt(s) or the insurance provider's explanation of benefits (EOB). Keep in mind, we cannot use canceled checks or copies of receipts as proof of payment. Once this form is completed, please submit it, including all **original** documentation, to university human resources for processing and record keeping. Supplemental reimbursements will not exceed $300 per eligible individual **per calendar year**. This reimbursement is available to all full-time faculty and staff, and their eligible dependents (i.e., a child under the age of 24 who is either a full-time student or an IRS eligible dependent), based on the calendar year (**January 1 through December 31**), even if they are not part of the University health insurance plan. **Receipts for services rendered must be submitted to university human resources before December 31 of the same calendar year in order to be eligible for reimbursement**. Requisitions for reimbursement will be processed at the end of each month. For complete details regarding the Supplemental Reimbursement Guidelines, please refer to:

http://www.cedarville.edu/Offices/Human-Resources/Work-Life-Assistance.aspx

Thank you

Name of faculty or staff member: ______________________________

Services were provided for: ❑ Employee, ❑ Spouse, or ❑ Eligible Dependent

If services were provided for a dependent child, please provide the following information:

Date of Birth: ___/___/___
Full-Time Student? ❑ Yes ❑ No
IRS Eligible? ❑ Yes ❑ No

Date(s) of service: ______________________________

Total amount of supplemental reimbursement requested: $ ____________

Please **print** your full name: ______________________________

Signature: ______________________________ Date of Request: ____________

Please do not write below-for office use only

University Human Resources Use Only:

Date received: ____________ *Initials of university human resources staff receiving the form:* ____________

Action taken: ❑ ***approved*** ❑ ***denied***

Reason Denied: ______________________________

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