University of Nebraska

SUPPLEMENTAL
REIMBURSEMENT ACCOUNT CLAIM FORM

NOTE: Use this form as a supplement only – must be attached to a signed claim form.

Part A. Employee Information

Name _____ Personnel Number __ __ __ __ __ __
Last First MI (located on pay advice)

Campus Phone _____ Campus Zip Code_____

Payroll Cycle: Biweekly _____ Monthly _____

Part B. Health Care Claim Information - *Continued*

Date of Service mm/dd/yy	Patient Name	Relationship to You	Name of Provider	Specifiy condition related to over-the-counter item.	Amount Requested
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				Total Health Care Amount Requested	**$**