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 _____ University ID 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	Specify condition related to over-the-counter item.	Amount Requested
___/___/___					
___/___/___					
___/___/___					
___/___/___					
___/___/___					
___/___/___					
___/___/___					
___/___/___					
___/___/___					
___/___/___					
___/___/___					
___/___/___					
___/___/___					
___/___/___					
___/___/___					
___/___/___					
___/___/___					
___/___/___					
___/___/___					
				Total Health Care Amount Requested	**$**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.