



HMO \$500 INPATIENT HOSPITAL CO-PAY REIMBURSEMENT REQUEST FORM

Send Documentation and Completed Form to: Villanova University, Human Resources Department 800 Lancaster Avenue Villanova, PA 19085 (610) 519-7900

Section 1: Employee Information

Date: HMO Plan Name: Name: SSN: Dept: Address: City: State: Zip:

Section 2: Patient/Hospital Information

Table with 5 columns: Patient Name, Relationship, Service Dates, Hospital Name, Amount. Contains 3 empty rows.

I certify that 1) I, or my eligible dependent, incurred these charges; 2) I have paid the \$500 copay(s) for the hospital inpatient admission(s) to the healthcare institution.

Employee Signature: Date:

Reimbursement Procedures for \$500 Inpatient Hospital Co-Pay for HMO Plans

- 1. Complete and sign this reimbursement form
2. Attach a copy of the Explanation of Benefits (EOB) for the hospital inpatient admission which indicates the co-pay paid by the employee OR a copy of the hospital bill which indicates the amount paid by the employee.
3. Attach proof of payment in the form of a cancelled check or credit card receipt.
4. You will receive a check payable to you for the \$500 co-pay by the end of the month submitted if request is received by the 20th of the month.

Reviewed & Processed By: