

NAVAJO NATION EMPLOYEE BENEFIT PLAN

REQUEST FOR OUT-OF-POCKET REIMBURSEMENT FOR HEALTH SERVICES or  
SUBMISSION OF ITEMIZED HEALTH CLAIM

Employer: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Member ID Number from Health Insurance Card \_\_\_\_\_

I HEREBY AUTHORIZE PAYMENT OF BENEFITS DIRECTLY TO:

Provider(s) of Service  Self for Reimbursement  \_\_\_\_\_  
Signature of Employee Date

Revised 09/2016

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**Attach an itemized invoice and a copy of payment receipt.**  
(Please refer to the Plan Document, Claims Procedures, page 78.)

Fill out the top portion and mail it to:

Navajo Nation Employee Benefit Plan  
Hawaii-Mainland Administrators, LLC  
P.O. Box 22009  
Tempe, AZ 85285-2009