Today's Date: ____/____/__ # of pages: Plan Year: **2017**

Employee Name:	Employer Name/Division Name: **Inter-American Development Bank Medicare Part B Reimbursement**	
Employee Address: ☐ Please check if change of address; you must also change with your HR department.		
Social Security Number or Member ID Number:	Home Phone: ( )	Cell Phone: ( )

Please note: Each Plan Participant Must File His/her Own Form.

Please indicate one of the following: ☐ New Request for Premium Reimbursement Or ☐ Change in Premium Cost

Name of Medicare Part B Premium Recipient	List the relationship to the IDB (employee, spouse, parent, etc.)	List the total monthly amount	Indicate the month the premium went into effect
1.			

Total Amount Requested: $_____ **Per Month**

I certify that the above listed expenses have been incurred by me or by my spouse or dependent(s) and that they have not been reimbursed under any other health plan; furthermore, I will not seek reimbursement of the expenses under any other health plan.

Employee's Signature: _____ **Date:** ____/____/____

Claim Submission Guidelines

- All reimbursements will be made payable to the IDB retiree.
- Send completed claims via fax or mail to P&A Group.

FAX: Toll-free (855) 362-7711 | **MAIL:** Flex Department, Attn: IDB Reimbursement Account 17 Court Street, Suite 500 Buffalo, NY 14202-3204

P&A Group Customer Service Information

Customer service representatives are available Monday - Friday, 8:30 AM - 8:00 PM ET.
WEBSITE: www.padmin.com **TOLL-FREE:** (800) 688-2611

Electronic Claim Submission

Upload and submit your claims directly to the P&A website from your mobile device or computer. Log into your P&A account for more information.