# Personal Accident and/or Illness
## Medical Expenses Form

**Policy Number (if known)** | **Insured Name** | **Claimant Name**

**Reimbursement is calculated as follows:**
**A - D in the case of no Medicare component**
**Please note: Federal Legislation prohibits us from contributing to out of pocket expenses against Medicare eligible services.**
**Please note: In the case of a "Medicare gap" being paid by your Health Fund, no further benefit is claimable through ACS Financial.**

| | | A | B | C | D | Office Use Only | |
|---|---|---|---|---|---|---|---|
| Date Expense Incurred | Item Description | Fee Charged | Scheduled Fee | Medicare Benefits | Health Fund Benefit | Amount Payable by Insurer | Details |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | Totals | | | | | | |