Customized • Dedicated • Service

FLEXIBLE SPENDING ACCOUNT
Reimbursement Request Form

NAME:	Last	First		MI		**SS#**	
ADDRESS:	Street	City	State	ZIP		**PHONE #**	( )

❑ **Please check if this is a new address**

What is Considered Proper Documentation for Reimbursement Requests?
Explanation of Benefits (EOB) or an itemized statement from the provider that includes the following information:
- Provider name
- Patient name
- Service(s) received or item(s) purchased
- Date of service (date services were performed, not the date payment was made)
- Amount of expense incurred after insurance payment

***** Credit card/payment receipts are not acceptable forms of documentation *****

❖ Information below must be completed

MEDICAL EXPENSE CLAIMS

Date of Service MM/DD/YY	Patient Name	Relationship	Name of Provider	Description of Service	Claim Amount
					$
					$
					$
					$
				Total :	$

DEPENDENT CARE CLAIMS

Date of Service		Dependent Name	Age	Dependent Care Provider Name	Dependent Care Provider Address	Provider Tax Id#/SS#	Claim Amount
							$
							$
						Total:	$

Provider Signature: _____ **Date:** _____/_____/_____
TO BE SIGNED AND DATED BY PROVIDER WHEN RECEIPT IS NOT PROVIDED TO PATIENT.

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act, punishable under law.

Employee Signature: _____ **Date:** _____/_____/_____

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