FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT REQUEST FORM

Employer Name:____

Employee Name:____________________________ **SS# or ID#:**______________

Address:__________________________________ **Telephone #:**______________

City:____________________ **State:**_____ **Zip:**______ **Is this a change of address?** Y or N

Flexible Spending Account (FSA)

Date of Service	Name of Provider	Type of Service	Name of Patient	Amount of Expense	Was this service covered by any insurance plan?
				$	Y / N
				$	Y / N
				$	Y / N
				$	Y / N
				$	Y / N
				$	Y / N
				$	Y / N
				$	Y / N
				$	Y / N
				$	Y / N
Total amount requested from your **FSA:**				$	

Please fill out all requested information completely. For further instructions, see Guidelines for Reimbursement *on the back of this form. If more space is needed, list additional requests on a separate page. Please include all requests in the total. A minimum request amount (as established in your plan document) may need to be met before a claim can be paid.*

I certify that I have actually incurred these eligible expenses. I understand that *expense incurred* means that the service has been provided that gave rise to the expense, regardless of when I am billed or charged for, or pay for the service. The expenses have not been reimbursed or are not reimbursable from any other source. I understand that any amounts reimbursed may not be claimed on my or my spouse's income tax returns. I have received and read the printed material regarding the reimbursement accounts and understand all of the provisions.

Employee Signature:____________________________ **Date**:______________

Guidelines for Reimbursement

NOTE: Incomplete or illegible submission may result in processing delays. Be sure to include all necessary information, and sign and date the form. Please make copies for your records, as these documents will not be returned. If you fax your claim, keep the original.

Health Flexible Spending Account

Attach a copy of the Explanation of Benefits (EOB) for each submission. All claims **MUST** be submitted to your insurance company prior to request for reimbursement. **Estimates for services that have not yet been incurred cannot be accepted.**

OR

Submit a paid receipt for your copays. **Credit card receipts, canceled checks, or cash register receipts cannot be accepted for copays. Itemized cash register receipts are acceptable for over-the-counter (OTC) items/supplies.**

OR

If you do not have insurance coverage, submit an itemized statement from the provider showing the provider's name and address, patient name, date of service and description of service and amount charged. Additionally, prescription expenses must include the drug name or number. **Balance forward or paid on account statements cannot be accepted.**

Orthodontic reimbursement: For the first request, submit a copy of the Service Agreement or contract itemizing the treatment period, down payment, monthly payment, banding date and amount covered by insurance, if any. For subsequent claims, submit a copy of your monthly payment coupon and/or itemized receipt each time you request reimbursement.

Health Care Expenses Generally Eligible for Reimbursement

You *Should* Claim

Fees for health services or supplies provided by physicians, surgeons, dentists, ophthalmologists, optometrists, chiropractors, podiatrists, psychiatrists, psychologists, or Christian Science practitioners.
Acupuncture.
Fees for hospital, ambulance, laboratory, surgical, obstetrical, diagnostic, dental and X-ray services.
Costs incurred, including room and board, during treatment for alcohol or drug addicti