FLEX BENEFIT ADMINISTRATORS
www.fbaflex.com

claims@fbaflex.com

PO BOX 800518
HOUSTON, TX 77280-0518
PHONE (713) 460-FLEX (3539)
FAX (713) 460-3550

Debit Card Purchase Substantiation Form

Employer: _____ EE # _____

Employee Name: _____ SS # _____

Email address: _____

Itemized Receipts:

Date of Service	*Name of Service Provider*	*Expense Description*	*Person for Whom Expense Incurred*	*Net Amount*
			Total Purchase	$0.00

NOTE: Proper backup of Debit Card purchase will be an ***itemized*** receipt that shows the date of service and the type of service OR will be the Explanation of Benefits (EOB) from the insurance carrier. **COPIES OF THE CHARGE CARD RECEIPT WILL NOT BE ACCEPTED.**

Read Carefully I have recently used my health care reimbursement plan debit card to pay for medical care expenses. I am submitting this form with the documentation to substantiate that such use of the card was for eligible expenses under the Plan. I understand that if any part or all of such use of the card was for ineligible expenses, I will be notified and required to repay the Plan any amount not eligible and I understand that unauthorized usage of my debit card will result in my debit card being suspended. I certify that I have not and will not seek reimbursement elsewhere for these expenses. I understand that I, alone, am fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided and that unless an expenses for which payment is claimed is a proper expense under the Plan, I am liable for payment of all related taxes including federal, state or city income tax on amounts paid which related to such expense. I also acknowledge that these expenses will not be claimed on my person income tax return.

_____ _____

Signature of Employee *Date*