FLEX BENEFIT ADMINISTRATORS

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Claim for Reimbursement Form

Employer: _____ EE #: _____

Employee Name: _____ SS #: _____

Address: _____ City: _____ ST: _____ Zip: _____

Email Address: _____

Unreimbursed Medical/Vision/Dental Expense Claims

Date Expense Incurred	***Name of Service Provider***	***Expense Description***	***Person for Whom Expense Incurred***	***Net Amount***
			Total Unreimbursed Medical Claim	0

NOTE: For prescription drugs, documentation will include a legible copy of the drug ticket (not the cash register receipt) which includes the date of fill, the amount, the name of the patient, the name of the doctor, the name of the drug and the name of the pharmacy. Or you may provide a "prescription history listing" from your pharmacy.

For over-the-counter medication (if covered), documentation will include the cash register receipt (showing the date of service) with the item circled (do not highlight). The item is to be ***clearly*** identified on the listing above. OTC medicine and/or drugs will need a Letter of Medical Necessity.

For "Payment Receipts" from hospitals and day-surgery facilities, where detailed itemized statements are not given, participant is to submit the Explanation of Benefits (EOB) from your insurance carrier. **PAYMENT RECEIPTS AND CREDIT CARD RECEIPTS WILL NOT BE ACCEPTED.**

Read Carefully The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which related to such expense. The undersigned participant also acknowledges that these expenses will not be claimed on their personal income tax return.

_____ _____

Signature of Employee *Date*