

Reimbursement Request For Flexible Spending Accounts

Employee Name: _____ SSN: _____ Company Name: _____

Telephone (include area code): _____ Home Address: _____

The above includes (check all that apply): Address Change Phone # Change Name Change City State Zip Code

Health Care FSA

<u>Date(s) of Service</u>	<u>Patient Name</u>	<u>Relationship</u>	<u>Description of Service</u>	<u>Over The Counter (OTC) Drug Name</u>	<u>OTC Drug Treatment Purpose</u>	<u>Amount of Request</u>

Total Requested Amount: _____

Dependent Care FSA

<u>Date(s) of Service</u>	<u>Dependent Name</u>	<u>Relationship</u>	<u>Age</u>	<u>Name of Care Provider</u>	<u>Amount of Request</u>

Total Requested Amount: _____

Please attach a copy of all receipts or bills for which reimbursements have been requested to this form. Receipts or bills must include date(s) of service, type of service received, the provider's name/address/phone number, family member receiving service, and the amount of the out-of-pocket expense incurred. **For recurring reimbursements for orthodontic services, please attach a copy of the orthodontic service contract from your provider with the first reimbursement request.** Administrative Solutions can only pay reimbursement requests when all required information and documentation has been received in our office. Failure to provide requested information may result in a delay in processing, or denial, of your reimbursement request. **Please mail or fax this form with a copy of your receipts or bills to the Administrative Solutions Claims Department at the address or fax number listed above.**

The undersigned Plan participant certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under the Plan with respect to such expenses and that such expenses have not been reimbursed, or are not reimbursable, under any other health plan. 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 by the undersigned, 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 the payment of all related taxes including Federal, State, or local income tax on amounts paid from the plan which relate to such an expense. The undersigned further understands that no tax deduction is permitted for amounts for which reimbursement is made. **The undersigned understands that an expense is incurred when the service is provided, not when paid for. Services must be incurred during the plan year and must be incurred and paid for prior to reimbursement of your claim.**

Employee Signature (You must sign this form to be reimbursed) _____

Date _____