FSA

Reimbursement Request Form

Employer			Employee Day Time Phone #		
Employee Last Name	First Name		Employee SS#		
Employee Street Address	☐ Check this box if new mailing address		City	State	Zip Code
Expenses Incurred by			Relationship to Employee		

ITEMS REQUIRED WHEN SUBMITING THIS FORM:
(1) Complete all pertinent information in the spaces provided, sign, date & return to ASI. Our contact information is below.
(2) Attach an itemized statement or receipt to support requested reimbursement(s).
(3) Your statement or receipt MUST include: Date of Service, Description of Expense & Amount of Expense.
Provider's Tax ID# or Certification # must be clearly listed for approval.

DATE OF EXPENSE:	EXPENSE TYPE:	REQUESTED AMOUNT:
☐ **UNREIMBURSED / MEDICAL RELATED**		
Month/ Date/ Year	1.	$
Month/ Date/ Year	2.	$
Month/ Date/ Year	3.	$
SUBTOTAL OF MEDICAL RELATED EXPENSE		**$**
Reimbursement check sent to: ☐Member OR ☐ Provider		
☐ **DEPENDENT DAY CARE**		
Month/ Date/ Year	1.	$
Month/ Date/ Year	2.	$
SUBTOTAL OF DEPENDENT DAY CARE REQUESTED		**$**

Dependent Day Care: Complete this section in lieu of statement or receipt for Dependent Care.

Provider's ID#:	Provider's Address:	
DEPENDENT NAME:	**DATE OF SERVICES:**	**AMOUNT BILLED OR RECEIVED:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____ _____
Dependent Care Provider Name | Signature of Provider | Signature Date

The undersigned participant in the Plan 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 benefit plan coverage. The undersigned fully understands that he or she alone is responsible for the sufficiency, accuracy, and authenticity 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 city income tax on amounts paid from the Plan which relate to such expense.

_____ _____
Plan Participant's Signature | Signature Date

P.O. Box 5809, Fresno CA 93755 / 5260 N. Palm Ave., Ste. 300, Fresno, CA 93704
Phone: (559) 256-1320 Fax: (559) 475-5782 Toll Free: (866) 777-1320 Email: flexhelp@asibenefits.com