MEDICAL REIMBURSEMENT ACCOUNT CLAIM FORM

EMPLOYER NAME: **COMMUNITY HIGH SCHOOL DISTRICT 155**

EMPLOYEE NAME: _____

SSN: ____ – ____ – ____

ADDRESS: _____

_____

SEND CLAIMS TO:
Group Administrators, Ltd.
Attention: FSA Administration
20 N Martingale Rd., Suite 290
Schaumburg, Illinois 60173

Telephone: (847) 519-1880
Fax: (855) 978-2331
e-mail: fsa@groupadministrators.com

____ **Check if Name Change** ____ **Check if Address Change**

EXPENSES TO BE REIMBURSED: (Please Itemize)

Date Medical Service Actually Provided	Provider Name or Facility of Service	Patient Name/ Relationship	Total Expense	Amount Paid by Insurance or Other Plan	Reimbursement Requested
1.			**$**	**$**	**$**
2.			**$**	**$**	**$**
3.			**$**	**$**	**$**
4.			**$**	**$**	**$**
5.			**$**	**$**	**$**
6.			**$**	**$**	**$**
				Total Requested	**$**

********The following section MUST be completed by the employee.********

EMPLOYEE CERTIFICATIONS & REQUIREMENTS FOR REIMBURSEMENT:

____ My spouse has insurance coverage through his/her employer's group health plan and my explanation of benefits or denial(s) is enclosed indicating what insurance is not paying. **THIS INFORMATION MUST BE INCLUDED IF YOU HAVE ANY INSURANCE COVERAGE**. ***Canceled checks or balance due receipts are not acceptable.***

I hereby certify that my request for reimbursement applies to claims for legitimate expenses incurred on the dates noted. I will not request reimbursement for these expenses from any other plan, and I will not claim these expenses on my income tax return to the extent I am reimbursed from my Spending Account.

SIGNATURE: _____ **DATE:** ____/____/____