FLEXIBLE SPENDING ACCOUNT

MEDICAL REIMBURSEMENT ACCOUNT CLAIM FORM

COMPANY NAME: _____

EMPLOYEE NAME: _____

ID NUMBER: ____ – ____ – ____

ADDRESS: _____

_____

____ Check if Name Change ____ Check if Address Change

SEND CLAIMS TO:
Group Administrators, Ltd.
Attention: FSA Administration
915 National Parkway, Suite F
Schaumburg, Illinois 60173

Telephone: (847) 519-1880
Fax: (847) 519-1979
EMAIL-fsa@groupadministrators.com

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:

____ I have insurance coverage through a group or private 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 am covered by an HMO Plan and my itemized paid receipts are attached for just my co-pay amount.

____ I am covered by a PPO or POS Plan. I have attached my itemized paid receipt for the co-pay amount(s) or I have attached my EOB for charges above the co-pay amount.

____ I have no insurance coverage, at all, for the above expense(s). I have attached the itemized bill and paid receipt. (i.e. vision)

____ Orthodontia Expenses. I have included my itemized paid receipt. If I have Orthodontia Insurance I have also included my most recent explanation of benefits.

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:** ____ / ____ / ____