D155
INSPIRE. EMPOWER. NURTURE.
Enter with promise. Leave with purpose.

COMMUNITY HIGH SCHOOL DISTRICT #155 SPOUSAL REIMBURSEMENT PROGRAM

MEDICAL REIMBURSEMENT ACCOUNT CLAIM FORM

EMPLOYER NAME: Community High School District #155

EMPLOYEE NAME: _____

SSN: _____

ADDRESS: _____

_____

_____*Check if Name Change* _____*Check if Address Change*

SEND CLAIMS TO:
Group Administrators, Ltd
ATTN: FSA Administration
20 N Martingale Rd, Suite 290
Schaumburg, IL 60173
Tel: (847) 519-1880
Fax: (847) 519-1979
www.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.					
				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 his/her explanation of benefits or denial(s) is enclosed indicating what his/her insurance is not paying. **THIS INFORMATION MUST BE INCLUDED TO RECEIVE REIMBURSEMENT. *Cancelled checks or balance due receipts are not acceptable.*** For prescriptions, be sure to include the itemized receipt showing the name of the drug.

I hereby certify that my request for reimbursement applies to claims for legitimate expenses incurred on the dates noted above. 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**

Rev. 03-04-20