

# 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

**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.			\$	\$	\$
				<b>Total Requested</b>	<b>\$</b>

**\*\*\*\*\*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:                    \_\_\_\_ / \_\_\_\_ / \_\_\_\_