



# Health FSA Reimbursement Form

Fax to: (866) 363-0182 For faster service, fax this entire sheet along with the appropriate documentation.

Employee Name: Last		First		Middle Initial		Social Security Number	
Home Address <input type="checkbox"/> check if new address		Number/Street		Apt#		City	
				ST		Zip	
Email Address <input type="checkbox"/> check if new email address		@		Company Name		Daytime Phone Number ( ) -	

To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for myself and/or my legal dependent(s). I certify that these expenses have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction. If there is a discrepancy between the total amount of expenses requested below and the total amount of the attached receipts, I will be reimbursed according to the total amount of eligible expenses on the attached receipts.

Employee Signature Verification X \_\_\_\_\_ Date \_\_\_\_\_  
Required to process reimbursement

**Step 1** Complete this section of the reimbursement form for eligible expenses incurred during your FSA plan year while you were a participant. Health care expenses must be processed by your insurance company first, they will provide you with an Explanation of Benefits (EOB). An expense is incurred when the service is provided, not when you are billed or pay for the service.

For Health Care expenses:	Date of Service	Claimant	Drug Name or Type of Service	Amount of Service
<ul style="list-style-type: none"> <li>You must complete the boxes in this section for each expense in order for your claim to be processed properly.</li> <li>Use additional page(s) if needed.</li> <li>An Explanation of benefits (EOB) from your insurance company or an itemized bill (receipt) is required to process this claim.</li> <li>Your receipts must contain the following:               <ul style="list-style-type: none"> <li>Date of Service</li> <li>Type of Service</li> <li>Provider of Service</li> <li>Amount of Service</li> </ul> </li> <li>Drug name must be stated on all receipts</li> <li>Copies of receipts for each expense claimed must be attached to the form.</li> <li>Expenses must be totaled on each page.</li> </ul>	/ /			\$ .
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	/ /			\$ .
	/ /			\$ .
<b>Total Health Care Expenses \$</b>				

**Step 2** Fax to (866) 363-0182 Return this completed reimbursement form and appropriate documentation. Requests received via fax will be processed within five business days after receipt. If you prefer, mail to Advanced Benefits Management, 1299 W Riverstone Dr, Coeur d'Alene ID 83814. Claims received via mail may require one additional day for processing. Please keep original receipts for your records as required by the IRS.

Visit [www.mybenefits247.com](http://www.mybenefits247.com) 24 hours a day to obtain account information and additional reimbursement forms.