ebms
The Benefit of Balance

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Request for Flex Reimbursement

Employer Name		Employer Group Number
Employees Last Name	First Name	Employee's ID Number
Address		E-mail Address

Health Care Expenses

Date of Service	Provider	Description of expense (office visit, co-pay, prescription, etc.)	Patient Name	Amount Requested
				$
				$
				$
				$
				$
				$
				$
				$
		Total amount requested		$

Dependent Care Expenses

Name of dependent	Date of birth	Daycare Provider Name & Tax ID number	Dates of Service	Amount Requested
				$
				$
				$
				$
				$
		Total amount requested		$

Participants must submit a copy of the receipt or bill for dependent care service detailing the name, address and tax ID/SSN of the provider as well as dates of service being claimed. Receipts are not necessary if the provider has signed the Request for Flex Reimbursement Form.
Note: The tax identification number or Social Security number of the provider is required on all submissions.

Daycare provider's Signature:_____ Date: _____

To the best of my knowledge and belief, my statements in the Request for Flex Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. The expense(s) has not been reimbursed or is not reimbursable under any other health plan coverage and will not be claimed as an income tax deduction. I authorize my Flexible Spending Account be reduced by the amount requested above.

Employee Signature: _____ Date: _____