



Flexible Spending Account Reimbursement Request Form

Benefit Express
P.O. Box 189
Arlington Heights, IL 60006
877-837-5017 (7:30am – 6:00pm CT)
253-793-3766 FAX

Please Complete
When Faxing:

Date: _____
Number of Pages: _____
Return Fax #: _____

CLAIM INFORMATION

Total Amount of Reimbursement Requested

\$ _____

Participant Signature: _____

Date: _____

I certify that all expenses listed on this request have not been reimbursed by any other source, nor will they be reimbursed by any other source. Additionally, I certify that I have read the reverse side of this claim form (page 2) and the expenses listed meet all of the IRS guidelines.

PARTICIPANT INFORMATION

Social Security Number
(optional): _____

Employer: _____

Employee Name:

(First Name)

(Middle Initial)

(Last Name)

E-Mail Address: _____

Current Address:

☐ Check if Change of
Address

(Street Address)

(Floor or Apartment Number)

(City, State, Zip)

(Daytime Phone Number)

(Evening Phone Number)

Helpful Hints to Expedite Your Reimbursement

Please follow these simple guidelines when submitting your claims for reimbursement:

- ✓ Please list one patient and service per line. The type of service field indicates what type of service was provided. For example, HC = Health Care, DC = Dependent Care, PK = Parking
- ✓ In accordance with IRS regulations, the actual date which services were rendered is required. Many providers and insurance bills have a separate billing date. Please do not mistake the billing date for the date services were performed.
- ✓ Fax tips: Please print information using black ink to ensure readable transmission. If the documents are faint, highlighted or distorted, they will not transmit clearly and may not be readable when we receive them. If the transmitted documents are not readable, a letter will be sent requesting legible documentation.

Reimbursement Guidelines

In order to receive reimbursement, supporting documentation must be attached to this completed claim form (including expense itemization). Please include an itemized statement from the provider listing dates of service, service performed, charge and the name of the patient receiving the service. If you have insurance, please submit the corresponding Explanation of Benefits (EOB) from your insurance company that details their payment and the amount for which you are responsible. If this claim form is incomplete a letter will be sent to you requesting completion before processing.

Date Services Were Provided	Patient Name	Name of Provider of Service	Type of Service (circle one only)	Net Amount
			HC DC PK	\$.
			HC DC PK	\$.
			HC DC PK	\$.
			HC DC PK	\$.
			HC DC PK	\$.
			HC DC PK	\$.
			HC DC PK	\$.
			HC DC PK	\$.

