Missoula County Risk & Benefits
200 West Broadway
Missoula, MT 59802
Phone (406) 523-4876
Fax (406) 523-4731

For additional forms, go to www.co.missoula.mt.us/benefits

FLEX MEDICAL EXPENSE REIMBURSEMENT REQUEST

Use this form to submit claims by fax or mail. Please complete the applicable spaces on this form, attach appropriate documentation, and forward to Missoula County Risk & Benefits Department. If any of these expenses were covered by your insurance or any other insurance, attach a copy of the "Explanation of Benefits" from your insurance company as documentation. For expenses not covered by insurance, send a copy of a bill or invoice identifying the service, service date, total charges and any discounts. If the required documentation is not attached, your reimbursement will be delayed.

Fiscal Plan Year: 2011/2012 Department _____ Daytime Phone# _____

Employee Name: _____ Soc. Sec. No. _____

Please Print. Last First

Home Address: _____

Street or Box Number City State Zip

UNREIMBURSED MEDICAL EXPENSE CLAIMS

Date(s) Incurred	Name of Provider, or Description of Service(s) Rendered	Covered by insurance?	Out-of Pocket Medical Expense(s)
		Yes ☐ No ☐	
		Yes ☐ No ☐	
		Yes ☐ No ☐	
		Yes ☐ No ☐	
		Total Medical Expenses (Minimum $10)	$

I certify to the best of my knowledge, the statements made within this Request for Reimbursement are complete and true. I certify the medical expenses were necessary to treat a medical condition for myself, my tax dependents, and/or spouse. I further understand that expenses reimbursed by Flex may not be claimed on my income tax return as an income tax reduction. I authorize my Flexible Spending Account to be reduced by the amount requested.

Employee's Signature _____ Date _____