FlexFit Reimbursement Form

This form should be used for services received from registered vendors only. Please fax or mail the Independent Health Reimbursement Form and itemized receipt to:

Independent Health
Attn: FSA Administration
P.O. Box 9066
Buffalo, NY 14231
Fax (716) 774-8092

Independent Health Use Only

Ref # _____
D/e Date _____
D/e By _____
Check # _____
Paid on _____

Please enclose copies of paid itemized receipt. All paid receipts require the date of service, description of services rendered, member receiving service and name of individual or organization providing service. Cancelled checks are not acceptable in lieu of a paid receipt.

Section 1 – Information (please print)

Name of Member Receiving Service _____

Independent Health ID Number *(refer to member ID card)* _____

Phone Number ( ) _____

Section 2 – Information (please print)

Dates of Services _____

Name of Individual or Organization Providing Service _____

Address of Individual or Organization Providing Service _____

Type of Service Received _____

Total Amount of Request *(receipt must be attached)* $ _____

Section 3 – Subscriber Signature

To the best of my knowledge and belief, my statements in this reimbursement form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible members. I certify these expenses have not been previously reimbursed in this or any other benefit year. I authorize my Independent Health FlexFit card to be reduced by the amount requested.

Subscriber's Signature _____ Date _____

Independent Health®