DirectPay

REQUEST FOR REIMBURSEMENT

PLEASE DUPLICATE THIS FORM FOR FUTURE CLAIMS:

Client ID#: _____

Participant ID#: _____

Name: _____

Address: _____

City/State/Zip: _____

☐ **New Address, check here and update - please print**

_____

_____

Supporting documentation must be maintained by Requestor.

Submit Request for Reimbursement:

BY FAX: **608-663-2754**

BY MAIL: **TASC**
PO Box 7308
Madison, WI 53704-7308

Date of Service
(not billing or paid date)

For each claim line entered, all boxes must be completed.

Month	Year	Benefit Code	Claim Amount	Service Type (List Service Provider(s))	Name of Insured
			.		
			.		
			.		

BENEFIT CODES

ME - Medical Expense **DE - Dental Expenses** **VI - Vision Expenses** **PH - Prescription Expenses**

To the best of my knowledge and belief, my statements in this Request for Reimbursement are complete and true. I am requesting reimbursement for eligible expenses incurred during the applicable Plan Year and for eligible Plan Participants. I certify that these expenses have not previously been reimbursed under this or any other benefit Plan and will not be claimed as an income tax deduction. In addition, if required by Plan design, I have depleted all available Flexible Spending Accounts before submitting this claim.

Employee Signature (required) _____ Date ___ / ___ / ___

REIMBURSEMENT TIPS - *To ensure prompt and accurate reimbursements.*

- ***Include along with your Request for Reimbursement an Explanation of Benefits (EOB) or required claim substantiation form.***
- Incomplete Requests for Reimbursement will delay processing.
- **Dates of Service always represents the date your services are incurred or rendered,** *not* the date they were paid for.
- Enter the amount requested for each claim in the Claim Amount Box. One request form can be used for multiple expenses.
- **Your signature is required** on *each* Request for Reimbursement Form.