DEPENDENT CARE FSA
REIMBURSEMENT REQUEST FORM

maestro health

UT Benefits
THE UNIVERSITY of TEXAS SYSTEM

INSTRUCTIONS:

1) Complete Employee Information requested in Section A
2) Complete Expense Information requested in Section B. Utilizing your receipts list each expense separately and attach the receipt to the back of the request form. If receipt(s) are not available, the provider must sign in Section B. Total the expenses on each form. Complete and attach additional request forms if necessary. Receipts or proof of payment must include:
   - The dependent name
   - The provider name/signature
   - The first and last day of services
   - The expense amount
3) Read the Employee Authorization in Section C carefully. Sign and date the request form.
4) Submit completed Reimbursement Request Form with attached receipts via:

Note: Save time and file claims online at www.myUTFLEX.com.

Fax to: 844.306.8147

Mail to: Maestro Health mSAVE
PO Box 2370
Matthews, NC 28106

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Important:

- To be eligible for reimbursement the dependent care expense must be incurred during the plan year, regardless of when payment is made or when billed.
- Reimbursement cannot be requested until after the last day of the service period.
- Incomplete or unsigned request forms cannot be processed.
- Retain the original receipt/s or a copy of the claim and receipts for your personal records

For assistance contact our Customer Advocates at: **844-UTS-FLEX or questions@maestrohealth.com**

A: EMPLOYEE INFORMATION: (Please print clearly)

Employer/Company Name:	Benefit ID or Last 4-digits of SSN:
Employee Name:	Daytime Phone Number:

B: EXPENSE INFORMATION:

Dependent Name	Provider Name/Signature	Dates of Service (mm/dd/yyyy)		Expense Amount
		From:	To:	$
		From:	To:	$
		From:	To:	$
		From:	To:	$
		From:	To:	$
		From:	To:	$
		From:	To:	$
			TOTAL SUBMITTED:	$

C: EMPLOYEE AUTHORIZATION:

I certify that my eligible dependent(s) have incurred expenses for which reimbursement is sought under my Employer's Flexible Spending Account Plan and that these expenses have been incurred during the Plan Year. I further declare that I am requesting payment only for expenses that have not and will not be paid under any other benefit plan or program; and that I am solely responsible for the accuracy and veracity of all information relating to this claim. I authorize the Employer to reimburse the amount requested from my Flexible Spending Account.

Employee Signature _____ **Date** _____