FlexFit
Debit Card Reimbursement Form

Independent Health use only	
Ref #	_____
D/e Date	_____
D/e By	_____
Check #	_____
Paid on	_____

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

Independent Health
Attn: FSA Administration
P.O. Box 9066
Buffalo, NY 14221 Fax (716) 774-8092

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 (_____) _____-_____

Section 2 – Unique Services

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 FlexFit Debit Card(s) to be reduced by the amount requested.

Subscriber's Signature _____ Dated _____

Independent Health