



**Medical Reimbursement Account
 (Section 105)
 Reimbursement Form**

Employee's
Full Name

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Address

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City,
State,
Zip Code

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Social Security Number

Name Of Employer

Employee Telephone Number

Please Note: If your address has changed or is incorrect, please call our Customer Service Department at the telephone numbers listed on the back of this form.

Instructions on reverse side

IMPORTANT: SIGNATURE REQUIRED BELOW

I certify the information here is true and correct, that the expenses incurred were for myself, spouse, or qualified dependents, and that these expenses are not reimbursable under any other health plan coverage.

DATE: _____ EMPLOYEE SIGNATURE: _____

Patient Name	Relationship To Employee <small>SELF/SPOUSE/CHILD OTHER (SPECIFY)</small>	Amount	Date(s) Of Service	Description Of Service	Does This Patient Have Insurance Coverage For This Service? (Y/N)	CLAIM REF #	OFFICE USE ONLY
						01	
						02	
						03	
						04	
						05	
						06	
						07	
						08	
						09	
						10	
						11	
						12	
						13	

INSTRUCTIONS

1. If you are submitting expenses eligible under another insurance plan, you **must** submit an Explanation of Benefits (EOB) statement.
2. Copies of **all bills (and EOB if required)** for reimbursement must be enclosed with this completed reimbursement form.

Bills must include:

- Name of person providing the service
- Dates of service
- Description of the service(s) rendered
- The amount charged
- The name of person receiving services

Balance bill, cancelled checks, etc. are **not** acceptable.

3. All claims must be received at least 3 business days prior to your scheduled reimbursement date.

If you have any questions, please call our Customer Service Department at: 585-325-3630 (Rochester Area) or 1-800-544-0328.

MAIL COMPLETED CLAIM FOR TO:

Attention: FSA Claims
EBS Benefit Solutions, Inc.
165 Court Street
Rochester NY 14647