



 F **S** **A** **Flexible Spending Account**
 A **Reimbursement Form**

Employee's Full Name		Social Security Number
		Name Of Employer
Address		Employee Telephone Number
City, State, Zip Code		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: _____

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	

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
- For over-the-counter drugs, circle or highlight the eligible item(s) on your receipt, and list each item separately on your reimbursement form.

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

3. Dependent care expenses must include:
 - Name and address of person providing care
 - Date(s) of service
 - Name of dependent receiving care
 - Amount Charged
 - Tax identification or Social Security number (if required by employer)
 - Receipt must be on provider letterhead or include provider signature

4. All claims must be received at least 5 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.

SEND COMPLETED CLAIM FORM TO:

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

Fax: 1-877-256-7228