FSA*Direct* REQUEST FOR MEDICAL REIMBURSEMENT

PLEASE PRINT CLEARLY. USE ALL CAPITAL LETTERS.

ACCOUNT HOLDER GENERAL INFORMATION

Group: Plan ID:

Partic. ID# If this is a new address check here ☐

Last First

Name

Address

City State Zip -

Phone ( ) - - E-Mail

IMPORTANT INSTRUCTIONS:

• You **must** attach an itemized bill or explanation of benefits (EOB) form for healthcare expenses. **Do not** attach checks or credit card slips as you may be required to provide additional documentation.

• Expenses that **CAN NOT** be reimbursed include cosmetic expenses, insurance premiums, and general wellness expenses.

• Fax the claim to 1-800-726-9982 or 704-335-0818 in the Charlotte area.

Or mail to: Claims Processing • P.O. Box 31397 • Charlotte, NC 28231-1397

Claim Submission Deadline:

You have until the above day after the end of the plan year to submit claims for the previous plan year.

REIMBURSEMENT REQUEST DETAIL

Please complete one section for each included receipt and total at the bottom. Use additional forms as needed.

Date Of Service (not payment date) Service Code (See key below) Amount Requested for Reimbursement

Patient Name Name Of Provider

Date Of Service (not payment date) Service Code (See key below) Amount Requested for Reimbursement

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Patient Name Name Of Provider

SERVICE CODE KEY

01 - Medical	03 - Vision	05 - Mileage	07 - Other
02 - Dental	04 - Prescription	06 - Orthodontia	08 Over The Counter

Total Requested For This Page

REIMBURSEMENT AUTHORIZATION

I certify that I have not previously requested reimbursement for the above expenses under this or any other plan and I am not able to receive additional insurance benefits or reimbursements from any other source for these expenses. I certify that these expenses are eligible for reimbursement in accordance with the Flexible Spending Account SPD provided by my employer. I further certify that these expenses are for eligible dependents as defined under Internal Revenue Code Section 152.

Participant Signature (Void if not signed) Date Signed