FIRST BENEFIT ADMINISTRATORS

FSA HEALTH CARE REIMBURSEMENT CLAIM FORM

To request reimbursement, please complete this form, including appropriate documentation and provide signatures where shown. In order to process your claim all required fields applicable to the claim must be completed including signatures. Please retain a copy of this claim form and supporting documentation for your records, as we are unable to return original documents to you.

Employer Name	
Employee Name (First & Last Name)	
Social Security Number	
Daytime Phone Number	
Address: ☐ *check if address has changed*	Street: City: State: Zip:
Email	

REQUIRED: COMPLETE ALL SECTIONS

In order to receive reimbursement, supporting documentation must be attached. Please include itemized bills from the provider listing exact service dates (balance forward statements are not acceptable), service performed, patient's name and cost. If other coverage, an explanation of benefits (EOB) from your insurance company listing the same information as shown above. Please retain a copy of this claim form and supporting documents for your records, as we are unable to return original documents to you.

Service Date	Patient Name	Cost	Service Provider	Description	Type
		$			☐M ☐Q ☐Y ☐E ☐G
		$			☐M ☐Q ☐Y ☐E ☐G
		$			☐M ☐Q ☐Y ☐E ☐G
		$			☐M ☐Q ☐Y ☐E ☐G
		$			☐M ☐Q ☐Y ☐E ☐G
		$			☐M ☐Q ☐Y ☐E ☐G
	Total:	$	FOR OFFICE USE ONLY ☐ Notified of Ineligible expense Date:		

Service Type Code: (M) Medical Dental (Q) Eye Care (Y) Prescription (E) All Other (G)

I certify that the expenses for which I am requesting reimbursement meet all the conditions listed below:

- They were incurred for services or supplies received by my eligible dependents or me under the plan.
- They were for services or supplies furnished on or after the effective date of my employee reimbursement account.
- I have not been reimbursed for these expenses in any other way or from any other source.

I further certify that I have not deducted nor will I deduct on my individual tax return any of the expenses reimbursed through my health care reimbursement account. I understand that reimbursement will be made in accordance with the provisions of the Plan. I accept sole responsibility for the proper treatment of benefits paid under this Plan with respect to eligibility, income tax reporting and liability. First Benefit Administrators shall not be liable for any penalties or damages as a result of an inappropriate claim filed by me. I will retain a copy of this form and all original receipts for my records. I further certify that the expense listed above have not been previously reimbursed under this or any other benefit plan.

Participant's Signature **Date**

PLEASE MAIL OR FAX THE COMPLETED SIGNED FORM TO: FIRST BENEFIT ADMINISTRATORS, INC
9455 Koger Blvd N. Suite 100, St. Petersburg, FL 33702 Phone: 727.530.4144 ◊ Fax: 727-532-9602
www.firstbenefitadmin.com