

**FSADirect 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

Name Last  First

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: Flores & Associates • 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) <input type="text"/>	Service Code (See key below) <input type="text"/>	Amount Requested for Reimbursement <input type="text"/>
Patient Name <input type="text"/>	Name Of Provider <input type="text"/>	
Date Of Service (not payment date) <input type="text"/>	Service Code (See key below) <input type="text"/>	Amount Requested for Reimbursement <input type="text"/>
Patient Name <input type="text"/>	Name Of Provider <input type="text"/>	
Date Of Service (not payment date) <input type="text"/>	Service Code (See key below) <input type="text"/>	Amount Requested for Reimbursement <input type="text"/>
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**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