



# Flexible Spending Account Reimbursement Account Claim Form

## PART A CLAIMANT DATA

Employer: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

\_\_\_\_\_

E-Mail: \_\_\_\_\_

Check Here if Address Has Changed

Check if communication by e-mail is authorized

### Individual(s) for Whom Claims Submitted:

Individual's Name:

Birthday:

Relationship to Employee:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

## PART B EXPENSES TO BE REIMBURSED

Date Expense Incurred	Expense Description & Name of Service Provider	Person for Whom Expense Incurred	Net Amount Eligible for Reimbursement
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

Attach copies of your medical/dental plan's explanation of benefits (EOBs) or paid receipts showing amounts not paid by those plan(s). If claiming expenses for non-prescription drugs or medications, the cash register receipt must show both product description and price or you must also submit product packaging showing product name & price. If claiming Dependent Care expenses, you must provide the name, address and social security or EIN number of each dependent care provider.

## PART C EMPLOYEE'S CERTIFICATION

**Read Carefully:** The undersigned participant in the Plan hereby certifies that all charges for the services and supplies for which reimbursement or payment is claimed herein were actually incurred during a period while the undersigned was a participant in the Plan and that the medical expenses claimed herein have not been reimbursed and will not be reimbursed by any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and truthfulness of all information relating to this claim, and that if any of the above items claimed are later determined to not be eligible for reimbursement under this Plan, the undersigned will be solely and completely liable for any and all state, local, and federal income taxes, penalties and fines payable on the amounts disbursed by the Plan on such ineligible claims.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date Submitted

Claims are administered by MVP Health Care, Inc. Mail completed claim and required receipts to: **MVP Ancillary Services Division, Flex Care Program, 620 Erie Blvd. West #200, Syracuse, NY 13204. Or fax claim form and receipts to Administrator: (315) 234-6146.** After you fax a claim and receipts, please **do not** follow-up with a hard copy in the mail. (Remember to keep the original claim form and supporting documents for your records.)

**Questions on your Reimbursement Account, please call 1-888-436-1613 OR go to [www.myflexonline.com](http://www.myflexonline.com)**