MEDICAL *Flexible Spending Account*
Request for Reimbursement

SECTION A: Employee Information (please print clearly in ALL CAPITAL letters)

Name: _____ Employee ID: _____
(FIRST NAME LAST NAME) (This may be your SSN or employer assigned number)

Employer: _____

Email: _____ Phone Number: _____

Address: _____
☐ Check here if new address

SECTION B: Claim information and Signature

PLEASE READ CAREFULLY: I certify that the expenses listed below have been incurred by me, my spouse and/or my eligible dependents during the plan year and while I was a participant in the plan. To the best of my knowledge all expenses below are eligible under the plan. I certify that any prescriptions drug expenses are for medical care and not cosmetic purposes. I understand that I am responsible for the accuracy of the information related to this expense. I have not and will not seek to be reimbursed through any other health plan coverage for any of the expenses listed below. I further declare that I will not deduct any of the reimbursed medical expenses listed below from my federal, state or local tax returns.

Total amount of this claim requested: $_____ Number of pages sent (do NOT fax a cover sheet): _____

Participant Signature: _____ **Date**: _____

SECTION C: Medical Claim details (please print clearly in ALL CAPITAL letters)

1) Provider: _____ Date of Service: _____ Amount: _____

2) Provider: _____ Date of Service: _____ Amount: _____

3) Provider: _____ Date of Service: _____ Amount: _____

4) Provider: _____ Date of Service: _____ Amount: _____

5) Provider: _____ Date of Service: _____ Amount: _____

6) Provider: _____ Date of Service: _____ Amount: _____

7) Provider: _____ Date of Service: _____ Amount: _____

8) Provider: _____ Date of Service: _____ Amount: _____

TOTAL AMOUNT OF MEDICAL REIMBURSEMENT REQUESTED: $_____

FAX THE CLAIM TO:

888-510-4218

or EMAIL TO:
Claims@hfsbenefits.com

If mailing, please keep the originals for your records.

Mailed claims can be sent to:
PO Box 1550
Hunt Valley, MD · 21030-1550

STOP BEFORE SENDING MAKE SURE YOU …

- Complete this form in its entirety. Failure to complete all sections can result in a delay in processing your reimbursement.
- Itemize all expenses on the claim form. List the provider name, date of service (the date the service was INCURRED), and the amount of each expense. Please use additional sheets if necessary. Do **NOT** indicate 'See attached' or 'Various' in any field.
- Attach proof of expense (invoice, receipt, EOB, etc.) in the order you have them listed above.
- Receipts, invoices, etc. must show the **date**, **type** and **amount** of service/product purchased.
- Circle the date and the amount requested on each receipt. Do NOT highlight.

STOP BEFORE SENDING MAKE SURE YOU DO NOT…

- Send in cancelled checks or credit card receipts. These are NOT acceptable.
- Send in a receipt listing 'BALANCE DUE' or 'BALANCE FORWARD'.
- Fax in your claim multiple times.

View your account online at www.hfsbenefits.com