Health Care Expense Claim Form

Flexible Spending Account

Plan Year: _____

Participant Name: _____ ***Employer:*** _____

Mailing Address: _____ ***SSN (Last four)*** ***XXX-XX-*** _____

City, State, Zip: _____ ***Participant Daytime Phone:*** _____

Check if New Address ☐ ***Email:*** _____

List Unreimbursed Medical Expenses by Classification *(Participants and IRS Eligible Dependents)*	**Dates of Service** MM/DD/YYYY START - END	**Amount** ($)
Medications	-	
Doctor/ Hospital Co-Pays and Deductibles	-	
Dental/ Eyes/ Hearing	-	
Medical Procedures/ Services and Therapy / Labs and Tests	-	
Over the Counter Items	-	
Other	-	
	Total	

- All claims require copies of bills/statements/receipts showing date and service. (IRS regulation)
- Cancelled checks/bank statement/credit card receipts are not adequate substantiation.
- Direct deposit payments are processed weekly and funds are typically in your account by the end of the week; however, the bank has 3 business days to post it to your account.
- Checks are mailed bi-weekly.
- Expenses must be incurred during the plan year or before the termination date of employment to be reimbursed. Claims must be received within 90 days after the plan year ends or termination date.
- Claims received by Monday are typically included in that week's processing.

Certification

I, the undersigned, have incurred the expenses listed above that qualify for reimbursement under my employer's flexible spending plan. I have not been and will not be reimbursed for these expenses from any source including, but not limited to: insurance, this plan, or other programs offered by my employer, my spouse's employer, or any other third party. I understand these expenses may no longer be claimed as deductions for income tax purposes since I am requesting reimbursement with funds deducted from my compensation on a pre-tax basis. I acknowledge I am solely liable for any taxes or penalties on ineligible expenses submitted through the medical flexible spending account. I, and only I, am responsible for the accuracy and validity of the submitted expenses and will retain substantiation. I hereby request reimbursement for these expenses, and, if applicable, reaffirm the authorization provided to ebm to directly deposit the reimbursement into my bank.

Participant's Signature: _____ **Date:** _____

Attach copies of receipts and mail, fax, or scan as a PDF and email to *cpaclaims@getebm.com*

Retain originals for your records

Items with an asterisk are potentially eligible with a Letter of Medical Necessity from a licensed physician.

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