

**FSADirect REQUEST FOR MEDICAL REIMBURSEMENT**

PLEASE PRINT CLEARLY. USE ALL CAPITAL LETTERS.

[Empty box]

**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) [ ]	Service Code (See key below) [ ]	Amount Requested for Reimbursement [ ]
Patient Name [ ]	Name Of Provider [ ]	
Date Of Service (not payment date) [ ]	Service Code (See key below) [ ]	Amount Requested for Reimbursement [ ]
Patient Name [ ]	Name Of Provider [ ]	
Date Of Service (not payment date) [ ]	Service Code (See key below) [ ]	Amount Requested for Reimbursement [ ]
Patient Name [ ]	Name Of Provider [ ]	
Date Of Service (not payment date) [ ]	Service Code (See key below) [ ]	Amount Requested for Reimbursement [ ]
Patient Name [ ]	Name Of Provider [ ]	

**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.

[Signature line]

Participant Signature (Void if not signed)

[Date line]

Date Signed