FBA

First Benefit Administrators

FSA HEALTH CARE REIMBURSEMENT REQUEST VOUCHER

EMPLOYER NAME: _____

To request reimbursement, please complete this form, including appropriate documentation and provide signatures where shown. In order to process your claim all required fields applicable to your claim must be completed including signatures. Please retain a copy of this claim form and supporting documentation for your records, as we are unable to return original documents to you.

LAST NAME _____ FIRST NAME _____ MI ____ SOCIAL SECURITY NUMBER _____

DAYTIME PHONE ( ) _____ ☐ Check box if address has changed

ADDRESS _____ CITY_____

STATE_____ ZIP CODE_____ E-MAIL _____

REQUIRED – COMPLETE ALL SECTIONS

In order to receive reimbursement, supporting documentation must be attached. Please include an itemized bill from the provider listing exact dates of service (balance forward statements not acceptable), services performed, patient's name and cost. If other coverage, an Explanation of Benefits (EOB) from your insurance company listing service dates, service performed and cost. Please retain a copy of this claim form and supporting documentation for your records, as we are unable to return original documents to you.

CLAIMS ARE PAID WHEN RECEIPTS TOTALING $ 50.00 OR MORE HAVE ACCUMULATED

SERVICE DATE	PATIENT'S NAME	COST	SERVICE PROVIDERS	DESCRIPTION
		$ _____		
		$ _____		
		$ _____		
		$ _____		
		$ _____		
	TOTAL	$ _____	FOR OFFICE USE ONLY ☐ Notified of Ineligible Expense Date:_____	

DESCRIPTION CODE: M-(MEDICAL) D-(DENTAL) V-(EYE CARE) P-(PRESCRIPTION) E-(ALL OTHERS)

I certify that the expenses for which I am requesting reimbursement meet all the conditions listed below:

- They were incurred for services or supplies received by my eligible dependents or me under the plan.
- They were for services or supplies furnished on or after the effective date of my employee.
- I have not been reimbursed for these expenses in any other way or from any other source.

I further certify that I have not deducted nor will I deduct on my individual tax return any of the expenses reimbursed through my health care reimbursement account. I understand that reimbursement will be made in accordance with the provisions of the Plan. I accept sole responsibility for the proper treatment of benefits paid under this Plan with respect to eligibility, income tax reporting and liability. Florida Benefit Administrators shall not be liable for any penalties or damages as a result of an inappropriate claim filed by me. I will retain a copy of this form and all original receipts for my records. I further certify that the expenses listed above have not been previously reimbursed under this or any other benefit plan.

_____ _____

Participant's Signature Date

NOTE: *Deadline for filing current year claims for reimbursement is 90 days after the end of the Plan year*

PLEASE MAIL OR FAX THE COMPLETED SIGNED FORM TO: **FIRST BENEFIT ADMINISTRATORS, INC**

13080 Belcher Road South, Suite A

Phone: 727.530.4144 ◊ Fax: 727.535.3977

www.firstbenefitadmin.com

Or Email:

info@firstbenefitadmin.com