

ICSO

FSA MEDICAL REIMBURSEMENT FORM

Name: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Please check here if this is a new address Email: _____

REIMBURSEMENT REQUEST DETAIL

(Please attach additional pages if needed)

Expense Type	Patient Name	Relationship	Provider of Service	Date of Service	Reimbursement Amount Requested

TOTAL FOR THIS PAGE:

Note: Expense Types: = **(M)**edical, **(D)**ental, **(O)**rthodontia, **(V)**ision, **(H)**earing, **(R)**over-the-counter Drugs, **(P)**rescription Drugs

Reimbursement Authorization: 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 125.

Participant Signature _____ Date _____

Instructions for Completing Request for FSA MEDICAL Reimbursement Form

To prevent delays in processing your reimbursement request, please complete this form as follows:

1. **Personal Data** - In the spaces provided, print your name, social security number, and address. Please indicate if your address is new and notify ICSO of any address changes.
2. **Expense Type** - Enter the code for the type of expenses incurred as follows:

M = Medical V = Vision R = Over-the-counter Drugs O = Orthodontia

D = Dental H = Hearing P = Prescription Drugs
3. **Patient Name** - Enter your name or the name of your dependent.
4. **Relationship** - Enter the dependent's relationship to you (for example: spouse or child).
5. **Provider of Service** - For health care expenses, enter the name of the person or facility that provided the service (for example: the doctor, clinic, etc.). Use a separate line for each expense request.
6. **Date of Service** - Enter the date the expense was incurred, not the date it was paid.
7. **Reimbursement Requested** - Enter the amount of the incurred expense.
8. **Total (reimbursement) for this page** - Add amounts of reimbursement requested and write in the total. You have until April 15th following the end of the Plan year to request reimbursement of expenses incurred during the Plan year.
9. **Employee Signature and Date** - Be sure to sign and date your request.
10. **Documentation Needed** - You **must** attach copies of required documentation to receive reimbursement. The required documentation includes: For expenses that must be submitted first to an insurance company or health care plan, attach a copy of the Explanation of Benefits form received from the insurance company or claims administrator. For non-covered medical expenses, attach a statement of expense showing the diagnosis, the incurred date, and the amount of expenses (for example, a physician's bill or pharmacist's prescription or receipt).

SEND YOUR COMPLETED REQUEST FORM, WITH THE REQUIRED DOCUMENTATION ATTACHED TO:

**MAILING ADDRESS: Claims Processing Center
P.O. Box 26046
Tampa, FL 33623**

FAX TO: (813) 849-6336