FLEXIBLE SPENDING ACCOUNT
Reimbursement Request Form

Instructions: Please print or type and complete all items under **Personal Information**. In order to receive reimbursement, you must submit an *Explanation of Benefits Statement* (if applicable) from your insurance carrier, or an itemized statement that includes the provider name, patient name, date of service, description of service, insurance responsibility (if applicable), and patient responsibility for each health care claim. For dependent care reimbursement you have two choices: (1) Fill out all items in the **Dependent Care Expenses** section and attach a receipt of your payment, **OR** (2) Fill in your dependent's name, age, date of service and the requested amount, and have your Day Care provider fill out the **Affidavit of Dependent Care Provider**. You must sign and date this form and attach any corresponding receipts in order for us to process this claim. You have permission to photocopy this form.

PERSONAL INFORMATION

Employer's Name Erlanger Health System	**Email Address** pie14all@gmail.com
Employee's Name Richard David Peterson	**Date of Request** 12/12/2013
Employee's Social Security Number 414 92 0453	**Daytime Phone Number** 423-987-7041

HEALTH CARE EXPENSES

Patient Name	Relationship	Age	Date of Service	Type of Service (Medical, Dental, etc.)	Requested Amount
1. Richard D. Peterson	Self	61	see attached EOBs	Medical	$941.95
2. " " "	Self	61	see attached EOBs	Pharmacy	$150
3. " " "	Self	61	see attached EOBs	Vision	$22
4. Beverly Q Peterson	Wife	60	see attached EOBs	Medical	$320.81
5. " " "	Wife	60	see attached EOBs	Pharmacy	385.66
6. Joshua K Peterson	Child	15	see attached EOBs	Medical	$320 ~~$360~~
7. " " "	Child	15	see attached EOBs	Pharmacy	$30
8. John S Peterson	Child	26	see attached EOBs	Medical	$355.37
				Total:	$2504.98

DEPENDENT CARE EXPENSES

Dependent's Name	Age	Date of Service From	Date of Service To	Requested Amount
1.				
2.				
3.				
		Total:		

AFFIDAVIT OF DEPENDENT CARE PROVIDER

I have provided adult/child care for _____, age _____, for the period beginning _____
And ending _____. Services were provided by _____ for a fee of $_____.

Signature of Provider	Tax ID# or SS	Date
_____	_____	_____

I, the undersigned, hereby certify that the above listed expenses have not been previously reimbursed from my Flexible Spending Account, nor are reimbursable from any other source. I hereby authorize Flexible Corporate Plans, Inc. to obtain necessary information from all physicians, hospitals, daycare providers, employers and all other agents in order to adjudicate the claim for reimbursement under the Benefit Plan established by my employer.

Richard D Peterson
Employee Signature

12/12/2013
Date

Flexible Corporate Plans, Inc.
P.O. Box 381717, Birmingham, AL 35238 ◆ 1-888-505-4557 ◆ Fax: 866-238-8224 ◆ claims_fc@tasconline.com