

MedCost Benefit Services

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Flex Plan Manual Claim Form

Flexible Spending Accounts For Health or Dependent Care

Account Holder Information		
Last Name	First Name	Group Number
Address (Check if new address) <input type="checkbox"/>		Member ID
Email Address	Contact Number	

Health Care Claims For Reimbursement

Note: Expenses must have been incurred during the plan year and not reimbursed from any other source or claimed on your personal tax return.

For all expenses attach a copy of itemized bills or the explanation of benefits from your insurance carrier that clearly state:

- 1) Name of person receiving the service 2) Nature of service or supply 3) Name and address of provider of service
 4) Amount charged 5) Date service was rendered

1)	<input type="checkbox"/> Rx <input type="checkbox"/> Over the Counter <input type="checkbox"/> Dental <input type="checkbox"/> Other:	<input type="checkbox"/> Office Visit <input type="checkbox"/> Hospital <input type="checkbox"/> Vision	_____ / _____ / _____ Beginning Service Date (MM/DD/YY)	\$ _____ Amount
			<input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse	
2)	<input type="checkbox"/> Rx <input type="checkbox"/> Over the Counter <input type="checkbox"/> Dental <input type="checkbox"/> Other:	<input type="checkbox"/> Office Visit <input type="checkbox"/> Hospital <input type="checkbox"/> Vision	_____ / _____ / _____ Beginning Service Date (MM/DD/YY)	\$ _____ Amount
			<input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse	
3)	<input type="checkbox"/> Rx <input type="checkbox"/> Over the Counter <input type="checkbox"/> Dental <input type="checkbox"/> Other:	<input type="checkbox"/> Office Visit <input type="checkbox"/> Hospital <input type="checkbox"/> Vision	_____ / _____ / _____ Beginning Service Date (MM/DD/YY)	\$ _____ Amount
			<input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse	
4)	<input type="checkbox"/> Rx <input type="checkbox"/> Over the Counter <input type="checkbox"/> Dental <input type="checkbox"/> Other:	<input type="checkbox"/> Office Visit <input type="checkbox"/> Hospital <input type="checkbox"/> Vision	_____ / _____ / _____ Beginning Service Date (MM/DD/YY)	\$ _____ Amount
			<input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse	

Total Health Care Expenses Being Claimed \$ _____

Dependent Care Reimbursement

Dependent care expenses are eligible for children through age 12 or for dependent, disabled adults. The IRS requires that the name, address, and tax id number of your dependent care provider be on file with the administrator.

Provider Name		Provider SS # / TIN	
Street Address	City	St	Zip
Provider Signature			Date
Dependent Name	_____ / _____ / _____ Service Date (MM/DD/YY)	to	_____ / _____ / _____ Service Date (MM/DD/YY)
			\$ _____
Dependent Name	_____ / _____ / _____ Service Date (MM/DD/YY)	to	_____ / _____ / _____ Service Date (MM/DD/YY)
			\$ _____
Dependent Name	_____ / _____ / _____ Service Date (MM/DD/YY)	to	_____ / _____ / _____ Service Date (MM/DD/YY)
			\$ _____

Total Dependent Care Expenses Being Claimed \$ _____

Important! To prevent delays, please attach paid receipts or copies of bills (not canceled checks) to verify expenses.

Certification

These expenses were incurred while I have been a covered participant, and to the best of my knowledge are reimbursable by the plan. I have not and will not be reimbursed for these amounts from any other source.

Signature	Date
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