



Mail completed form to: Meritain Health
P.O. Box 30111
Lansing, MI 48909

Fax to: 888.837.3725
Customer Service: 800.748.0003

REIMBURSEMENT REQUEST FORM

Employer Name: Kellogg Community College

Employee Name: _____ SS# or ID#: _____

Address: _____ Telephone #: _____

City: _____ State: _____ Zip: _____ Is this a change of address? Y or N

Select account from which you are requesting reimbursement, and fill out all requested information completely.
For further instructions, see Guidelines for Reimbursement on back of this form.

Flexible Spending Account (FSA)

Date of Service	Name of Provider (Ex: physician, hospital, dentist, pharmacy)	Type of Service (Ex: copay, Rx, ortho)	Name of Patient	Amount of Expense	Was this service covered by any insurance plan?
				\$	Y / N
				\$	Y / N
				\$	Y / N
				\$	Y / N
				\$	Y / N
Total amount requested from your FSA:				\$	

If more space is needed, list additional requests on a separate page. Please include all requests in the total.
A minimum request amount (as established in your plan document) may need to be met before a claim can be paid.

Dependent Care Account (DCA)

Name of Day Care Provider	Dates of Service		Dependent's Name	Date of Birth	Amount of Expense
	From	To			
					\$
					\$
					\$
Total amount requested from your DCA:					\$

Provider Signature: _____ Provider SSN# or Tax ID: _____

Signature not required if signed receipt or Day Care Center statement is attached. Altered receipts cannot be accepted.

I certify that I have actually incurred these eligible expenses. I understand that *expense incurred* means that the service has been provided that gave rise to the expense, regardless of when I am billed or charged for, or pay for the service. The expenses have not been reimbursed or are not reimbursable from any other source. I understand that any amounts reimbursed may not be claimed on my or my spouse's income tax returns. I have received and read the printed material regarding the reimbursement accounts and understand all of the provision.

Employee Signature: _____ Date: _____