# FSA

## Health Care Account Request for Reimbursement

MERITAIN HEALTH

**Complete and send to:**
Meritain Health
Flexible Spending Accounts
PO Box 30111
Lansing, MI 48909
Fax: 1.888.837.3725

**NOTE:** Refer to your flexible spending account plan booklet for minimum and maximum dollar amount requirements for submitting expenses. Make copies of bills, receipts, and other supporting documentation for your files, as they will not be returned.

## EMPLOYEE INFORMATION

**Is this a new address? Yes__ No__**

| Name *(last, first, initial)* | | Sex | Employer Name/Location | |
|---|---|---|---|---|
| Home Address | | Identification Number | Birthdate | Group/Member No. |
| City | State | ZIP Code | Work Telephone ( ) | Home Telephone ( ) |

## PATIENT INFORMATION (IF DIFFERENT FROM EMPLOYEE)

| Dependent's Name(s) (last, first, initial) | Relationship to employee |
|---|---|
| | |

## HEALTH CARE ACCOUNT EXPENSES

*List the eligible expenses not covered by any health benefit plan (attach proof if applicable). Attach an Explanation of Benefits (EOB) form, a receipt, or other evidence for each expense listed. Reimbursement will only be considered for expenses incurred within the dates you participate in this plan. Refer to your plan booklet for details on how long after your particicaption ends that you may submit eligible expenses.*

| Date(s) Incurred | Type of Expense | Amount | Was this service covered by any insurance plan? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## EMPLOYEE'S SIGNATURE REQUIRED

It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts. I certify that the above information is correct. I also certify that I have not received nor will seek reimbursement previously for these expenses from the FSA or any other plan, and I know of no fact that makes me question whether this expense is properly reimburseable under the plan. I understand that reimbursement is not a guarantee that this payment is tax-free, and that reimbursed expenses cannot be used to claim a credit or deduction on my personal income tax return.

Signature _____ Date _____

**Meritain Health Toll-Free Customer Service:** 800-748-0003