benetech

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Flexible Spending Account

MEDICAL EXPENSE RECOVERY FORM

See reverse side for instructions regarding completion of this form.

Your Employer ______________________________

Your Name ______________________ **Your ID#** ______________

Your Home Address ______________________________
(Street) **(City)** **(State)** **(Zip)**

If this is a new address, check here ☐

Patient Name(s)	Relationship To Employee	
	☐ Child ☐ Spouse ☐ Other	☐ Self
	☐ Child ☐ Spouse ☐ Other	☐ Self
	☐ Child ☐ Spouse ☐ Other	☐ Self

When submitting this form you must complete the information requested and attach an ***Itemized Receipt*** or an ***Explanation of Benefits*** from your insurance carrier.

Date(s) of Service	Provider Name	Total Reimbursement Requested

By signing and submitting this form you acknowledge that all requirements of Section 213(d) of the IRS code, as well as the plan document of your employer, have been satisfied.

Any Person Who Knowingly, and With the Intent to Injure, Defraud or Deceive any Employer or Administrator, Files a Statement of Claim Containing any False, Incomplete or Misleading Information May be Guilty of a Criminal Act Punishable Under Law.

Your Signature ______________________ **Date** ______________

I hereby certify that the above statements are complete and accurate to the best of my knowledge. I also agree to reimburse my employer and/or the administrator of an overpayment which is in excess of the amounts payable under the plan.

REVISED; February 2011