Flexible Spending Account
Request for Reimbursement Supplement

Employee Name	Employee Identification Number	Phone Number

HEALTH CARE REIMBURSEMENT INFORMATION

Attach this form and related original receipts to your signed Flexible Spending Account Request for Reimbursement. Receipts must list patient, provider of service, service date and amount. Only expenses for employee, spouse or dependent are eligible for reimbursement. Canceled checks, credit card receipts or bills showing only a payment or previous balance are not acceptable.

Patient	Relationship	Provider of Service	Date(s) of Service	Total Amount of Expense	Less Amount Paid by Insurance	Amount to be Reimbursed
				Subtotal of Health Care Expenses		