Benetech
benefits · payroll · hr
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Flexible Spending Account
Medical Expense Recovery Form

See reverse for instructions regarding this form.

Your Employer's Name and Address: _____

Your Name: _____ **Your ID#:** _____

Your Home Address: _____
(Street) (City) (State) (Zip)

☐ If new address check here

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

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 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.

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FSA Medical
Expense Recovery Form

I hereby certify that any amounts reimbursed to me under this Plan:

1. will not be claimed as a deduction on my personal income tax return; and,
2. will not be reimbursed to me by other health plan coverage, including a Health Reimbursement Arrangement (HRA) plan or Health Savings Account (HSA) plan

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.

➡ **YOUR SIGNATURE** _____ DATE _____

Instructions for completing this Flexible Spending Account

MEDICAL EXPENSE RECOVERY FORM

The form should be completed and signed by the Employee who established the Flexible Spending Account with the Employer listed in the first section on page 1

- Enter your name, Employee ID Number (last 4 digits of your Social Security Number), and your home address.
- Check the box if this is a new address.
- List the patient(s) name(s) and relationship(s) to you (the employee). Reimbursement requests for multiple family members may be submitted on the same form.
- List earliest date of service through the last date being submitted. For example: (6/5/07-6/16/07). List the name(s) of the provider(s). Indicate the grand total requested for reimbursement.
- **The Employee's signature is required,** as indicated by the bold arrow. Please date the form as well in the space provided.
- This claim form and supporting documentation {receipt(s); carrier Explanation(s) of Benefits forms, etc.} may be submitted to Benetech via:
    - **US mail --** to the address at the top of page 1; or,
    - **Fax** – to 518.283.2384*****; or,
    - **Email** – to flexinfo@benetech.cc

*** NOTE: as of January 2011, this is a new fax number.**