Request for Reimbursement
FSA
CLAIM FORM

NAME:	Last First MI	**SS#**	
ADDRESS:	Street City State ZIP	**PHONE**	( )

☐ **Please check if this is a new address**

Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this claim.

* Information below must be completed

MEDICAL EXPENSE CLAIMS

Date of Service MM/DD/YY	Patient Name	Relationship	Name of Provider	Description of Service	Claim Amount
					$
					$
					$
					$
					$
					$
					$
				Total:	$

DEPENDENT CARE CLAIMS

Date of Service From	To	Dependent Name	Age	Dependent Care Provider Name	Dependent Care Provider Address	Provider Tax Id# or SS#	Claim Amount
							$
							$
							$
							$
						Total:	$

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ Date: _____ /_____ /_____

FOR FASTEST REIMBURSEMENT, FAX TO 801.561.5056 OR EMAIL TO CLAIMS@CBSESERVICES.COM

OR MAIL TO: CUSTOM BENEFIT SOLUTIONS
244 WEST HWY 40 333-8, ROOSEVELT, UT 84066

FOR QUESTIONS PLEASE CALL 866-656-0227