P.O. Box 348
One Dodge Street
North Greenbush, NY 12198
(518) 283-8500
Fax (518) 283-2393
800-698-4753
www.wedobenefits.com

Flexible Spending Account

MEDICAL EXPENSE RECOVERY FORM

See reverse for instructions regarding this form.

EMPLOYER (COMPANY) NAME AND ADDRESS: ______________________

EMPLOYEE NAME: ______________________ EMPLOYEE ID# ______________________

ADDRESS: ______________________
(street) (city) (state) (zip)

☐ If new address check here

PATIENT(S) 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.

DATES OF SERVICE	NAME OF PROVIDER	TOTAL OF AMOUNTS REQUESTED FOR REIMBURSEMENT

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.

➡ EMPLOYEE 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.

MEDICAL FLEX INSTRUCTIONS:

Instructions for completing the Flex claim form:

- The Employer is the name of your company.
- Enter the Employee (your) name, the Employee ID Number (which is your Social Security Number), and the Employee Address.
- Check the box if this is a new address.
- List the patient(s) name(s) and relationship(s) to the employee. The entire family may be submitted on one claim 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.
- **Signature is required,** as indicated by the bold arrows. Please date the form where appropriate.

This claim form and receipts may be submitted via mail, fax, or e-mail (lindas@benetech.cc).