PATIENT ADVOCATES
THE WAY HEALTHCARE SHOULD BE

FLEXIBLE SPENDING REIMBURSEMENT REQUEST FORM
(FSA)

ALL DISBURSEMENTS FROM THE REIMBURSEMENT ACCOUNTS WILL BE MADE PAYABLE TO THE EMPLOYEE.

Name	ID #
Address (Street)	Employer
Address (City,State,Zip)	Group Number

HEALTH CARE REIMBURSEMENT ACCOUNT

- List reimbursable expense and attach explanation of benefits or itemized bill.
- If an expense is covered in part by a health plan, the balance may be submitted for reimbursement only after all health plan benefits from all sources have been paid. If no health plan benefit applies write "none" in the Plan Payment column.
- Attach a second form if you need additional space.

Expense For			Dates of Service		Total Bill	Plan Payment	Reimbursement
First Name	Age	Relationship	From	To	(Attach Copy)	(Attach EOB)	Amount Due
			TOTALS				

DEPENDENT CARE REIMBURSEMENT ACCOUNT

- You must have an itemized bill, or have the provider sign this form. The taxpayer ID # from each person providing care is required.
- List each dependent receiving care on a separate line. List each provider on a separate line.
- Attach appropriate documentation information.

Dependent's Full Name	Age	Relationship	Dates of Care		Name of Provider of Care	Amount
			From	To		
Federal Taxpayer ID # or Social Security # of Provider: (Required)						
Federal Taxpayer ID # or Social Security # of Provider: (Required)						
Federal Taxpayer ID # or Social Security # of Provider:						
1. I certify that the above listed expenses have been incurred by me or my eligible dependents (as defined by the IRS).					TOTAL	

1. I certify that all applicable insurance or other health benefits have been exhausted.
2. I certify that I will not deduct or take as a tax credit on my Federal Income Tax Return these reimbursements.
3. I will assume all responsibility for taxes and penalties arising out of any disallowed deductions.
4. I have received the taxpayer ID # of my care provider.

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SIGNATURE:_____ DATE: _____

SIGNATURE OF CARE PROVIDER:_____ DATE: _____

MAIL TO**: PATIENT ADVOCATES, LLC * P.O. BOX 1959 * GRAY, ME 04039* Fax #: 207 657 7744**