



Company: _____
(required)

**BENEFIT MANAGERS COMPANY
REIMBURSEMENT REQUEST FORM**

Name: _____

SSN: _____
(optional)

Please select which of the following accounts you would like reimbursement from:

___ Medical FSA

___ Dependent Care FSA

___ Health Reimbursement Account

___ Bridge HRA

Proof of expense is required for reimbursement. Incomplete or undocumented requests will not be reimbursed.

Each Medical FSA and HRA claim must clearly indicate:

1. Date services incurred (this may not be the same as payment date)
2. Provider's name
3. Patient's name
4. Procedures provided
5. Amount of patient's responsibility
6. Prescription drug reimbursement requests must include name of drug, patient's name and amount

Each Dependent Care FSA claim must clearly indicate:

1. Provider's name
2. Dependent's name
3. Date of service
4. Amount due provider

Bridge HRA reimbursement requires documentation of deductible amounts met.

My signature below attests that I have read and understand the requirements for submitting a claim and the reimbursement being requested is: for a qualified participant (myself, spouse or dependent); (b) has been incurred as eligible; (c) qualifies as medical care under Code § 213(d) (is not for cosmetic purposes, general health purposes or toiletries); (d) has not previously been reimbursed (and will not be reimbursed) from any other health plan coverage; and (e) will not be used to claim any other deduction.

Employee Signature

Date

Change of Address or Phone Number?

Street: _____

City/State/Zip _____

Phone: _____

Please mail or FAX this form and receipts to:

Benefit Managers Company
P.O. Box 190840
Boise ID 83719

FAX: 208-672-8330 or 1 (888) 672-8330

Questions: call: 208-322-6546