Flexible Spending Account Manual Claim Form

Employee Information

(Please check if this is a new address ☐)

Last	First	MI

Street Address	City	State	Zip

Social Security Number	Employer Name

Telephone Number	Email Address

Health Claims

Patient Name	*Relationship to Employee*				*Provider Name*	*Description of Services*	*Date Service Performed*			*Requested Amount of Reimbursement*
	Self	*Spouse*	*Child*	*Other*			*Month*	*Day*	*Year*	
									TOTAL:	

When filing for expenses *eligible under your insurance, but not paid* (deductibles, co-insurance, etc.), be sure to attach copies of the explanation of benefits from your insurance company showing the extent of reimbursement or denial of claims.

For expenses that *are not eligible under your insurance*, attach a receipt or itemized bill that includes the information requested above. *Cancelled checks or bills only showing a balance due are not acceptable.*

Dependent / Child Care Claims

Proof of expenses must be attached and must include: dates of services, the provider's employer identification number or social security number, and the address of the provider. Proper completion of the following information will be considered proof of expense.

The dependent care information, including provider(s) name, address, TIN/SSN is correct to the best of my knowledge. I understand I may incur penalties of perjury if the information is knowingly misstated.

Name of Dependent Receiving Care	*Age*	*Provider Signature*	*Provider Address*	*TIN/SSN*	*Dates Services Performed*			*Requested Amount of Reimbursement*
					Month	*Day*	*Year*	
							TOTAL:	

I request reimbursement from my Flexible Spending Account(s) as listed above and certify that these are legitimate expenses, which my dependents or I have incurred. I understand expenses must qualify as deductible expenses for Federal Income Tax purposes and cannot be reimbursed by any other source or used as a deduction on my personal income tax return(s).

I, the participant, certify that I am familiar with and understand the Plan requirements contained in the Summary Plan Description; that the amounts herein requested for reimbursement have actually been incurred as eligible Plan expenses during the Plan Year; I, the participant, certify that I have not been reimbursed for the above expense(s) and that I will not seek reimbursement under any other plan covering health benefits.

Participant Signature **Date**

Send completed form along with proof of expense to:

Benefit Management Administrators, Inc.
Attention: Flexible Benefits Department
11550 I.H. 10 West Suite 220
San Antonio, Texas 78230
Or fax to 210-697-0360 ◆ Or email to flex@bmatpa.com