

**Health Care Account
Flexible Spending Reimbursement
Request Form**

Name: _____ **Employer:** _____

Social Security Number: _____ - _____ - _____

How To File Requests

- Submit a Reimbursement Request Form each time you request payment from your Flexible Spending Account.
- Complete and sign this form. Attach documentation.
- Mail to address below.
Professional Benefits Group
701 Chestnut Street
Vestavia Hills, Alabama 35216
- Since documentation cannot be returned to you, please be sure to make copies for your records.
- For assistance, call Professional Benefits Group, Inc. at 205.822.8310, or fax us at 205.822.8336

Important Information

- Requests cannot be processed without supporting documentation showing proof of expense (such as itemized copies of doctor bills or explanation of benefits from the insurance company).
- If you are reimbursed for expenses through your Flexible Spending Account(s), you cannot claim these same expenses on your federal income tax return.
- Expenses incurred prior to the effective date of your Flexible Spending Account(s) are not eligible.
- In general, you may request reimbursement for health care expenses which are allowed by the IRS as medical tax deductions and which are not covered by insurance or any other source.
- Health care expenses covered by insurance must be submitted under that plan first. Explanation of Benefits (EOB) and copies of itemized bills must show the following:
 - Name and address of service provider
 - Nature of service or item
 - Amount charged
 - Date(s) service rendered
- Balance due statements are not acceptable proof for health care expenses.

————— Please complete the following when applicable —————

A. Medical/Dental Care Expenses

Name of Provider	Date of Service	Requested Amount
_____	___/___/___	\$ _____
_____	___/___/___	\$ _____
_____	___/___/___	\$ _____
_____	___/___/___	\$ _____

B. Prescription Expenses

Name of Provider	Date of Service	Requested Amount
_____	___/___/___	\$ _____
_____	___/___/___	\$ _____
_____	___/___/___	\$ _____
_____	___/___/___	\$ _____

C. Individual (Non-payroll) Medical Premiums

Name of Carrier	Date of Service	Requested Amount
_____	___/___/___	\$ _____

NOTE: Date of Service/Coverage must be consistent with the play year from which you are requesting this reimbursement.

D. Total of Above Reimbursement Requests \$ _____

NOTE: If you have insurance, please attach a copy of the Explanation of Benefits (EOB) from the insurance company showing payment or no payment.

I request payment from my Flexible Spending Account(s) for the expenses listed above. I certify the above information is correct and I have not requested reimbursement for these expenses under my medical or dental plan or from any other source. I understand reimbursed expenses cannot be claimed on my personal income tax return and payment by Professional Benefits Group, Inc. is not a guarantee my expenses are tax deductible.

Signature: _____ **Date:** _____