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North Greenbush, NY 12198
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Toll-Free: 800.698.4753
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Flexible Spending Account

MEDICAL EXPENSE RECOVERY FORM

See reverse side for instructions regarding completion of this form.

Your Employer _____

Your Name _____ **Your ID#** _____

Your Home Address _____
(Street) (City) (State) (Zip)

If this is a new address, check here ☐

Patient 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.

Date(s) of Service	Provider Name	Total Reimbursement Requested

By signing and submitting this form you acknowledge that all requirements of Section 213(d) 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.

Your 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.

REVISED; February 2011

Instructions for completing this Flexible Spending Account

MEDICAL EXPENSE RECOVERY FORM

The form should be completed and signed by the Employee who established the Flexible Spending Account with the Employer listed in the first section on page 1

- Enter your name, Employee ID Number (last 4 digits of your Social Security Number), and your home address.
- Check the box if this is a new address.
- List the patient(s) name(s) and relationship(s) to you (the employee). Reimbursement requests for multiple family members may be submitted on the same 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.
- **The Employee's signature is required,** as indicated by the bold arrow. Please date the form as well in the space provided.
- This claim form and supporting documentation {receipt(s); carrier Explanation(s) of Benefits form(s), etc.} may be submitted to Benetech via:
    - **US mail** -- to the address at the top of page 1; or,
    - **Fax** – to 518.283.2384*; or,
    - **Email** – to flexinfo@benetech.cc

* **NOTE: as of January 2011, this is a new fax number. Please use this number for all your Flex claims submissions.**