Flexible Spending Account Request for Reimbursement

Company: ________________________________ **Plan Year:** _______________

Employee First Name	Employee Last Name
Employee ID No.	Daytime Phone #
Home Address ☐ Check here if new address	
E-Mail Address ☐ Check here if new address	

Unreimbursed Medical Expenses

Date(s) of Service	Physician or Other Provider	Expense Amount
	Total Amount Requested	

Dependent Care Expenses

Date(s) of Service	Provider	Expense Amount
	Total Amount Requested	

Dependent Care Provider Signature (If no receipt is provided)

I certify that the above listed Dependent Care charges have been incurred.

Provider Signature	Date

Participant Statement

I certify that the expenses listed above have been incurred by me, my spouse and/or my eligible dependents during the plan year and while I was a participant in the plan. To the best of knowledge all expenses listed above are eligible for reimbursement under the plan. I certify that any prescription drug expenses submitted are for medical care and not cosmetic purposes (e.g., Propecia for male pattern baldness, Retin-A for smoothing wrinkles, etc.). I understand that I am responsible for the accuracy of the information related to this request. I have not and will not seek to be reimbursed through any other health plan coverage and/or dependent care assistance plan for any of the expenses listed above. I further declare I will not deduct any of the reimbursed medical expenses listed above from my federal, state or local tax returns.

Participant signature	Date

Please email, mail or fax claim forms to:
claims@hfsbenefits.com
Claims Department, HFS Benefits
P.O. Box 1550, Hunt Valley, MD 21030-1550
Phone: 410.771.1331 / Toll Free: 888.460.8005
Fax: 410.771.5533 / Toll Free 888.510.4218
******PLEASE DO NOT MAIL ORIGINALS******

Have you visited www.hfsbenefits.com?

- ACCESS YOUR ACCOUNT BALANCE
- Frequently Asked Questions
- View A-Z list for eligible expenses
- Submit Questions