HEALTHCARE FLEXIBLE SPENDING ACCOUNT
Reimbursement Request Form

Instructions: Please print or type and complete all items under **Personal Information**. In order to receive reimbursement, you must submit an *Explanation of Benefits Statement* (if applicable) from your insurance carrier, or an itemized statement that includes the provider name, patient name, date of service, description of service, insurance responsibility (if applicable), and patient responsibility for each medical care claim. You must sign and date this form and attach any corresponding receipts in order for your claim to be processed promptly. You have permission to photocopy this form.

PARTICIPANT INFORMATION	
Employer's Name Girl Scouts of West Central Florida	**Email Address**
Employee's Name	**Date of Request**
Employee's Member ID Number	**Daytime Phone Number**

HEALTHCARE EXPENSES					
Patient Name	**Relationship**	**Age**	**Date of Service**	**Type of Service (Medical, Dental, etc.)**	**Requested Amount**
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
				Total:	

I, the undersigned, hereby certify that the above listed expenses have not been previously reimbursed from any insurance plan, nor are reimbursable from any other source. I hereby authorize Preferred Benefit Administrators, Inc. to obtain necessary information from all physicians, hospitals, employers and all other agents in order to adjudicate the claim for reimbursement under the Flexible Spending Account Plan established by my employer.

Employee Signature _____ **Date** _____

SEND REIMBURSEMENT REQUESTS TO:
PREFERRED BENEFIT ADMINISTRATORS, INC.
P.O. Box 916188, Longwood, Florida 32791-6188, (407) 786-2777, Toll Free: 1-888-524-2777
Fax: (407) 786-2999 or Claims@PreferredTPA.com