Flexible Spending Account - FSA Reimbursement Request Form

Mail: Core Management Resources
P.O. Box 90
Macon, GA 31202
Fax: 478-750-1705

Please print clearly

EMPLOYER | PLAN YEAR

EMPLOYEE NAME | MEMBER ID# or SSN

ADDRESS | CITY | STATE | ZIP CODE | DAYTIME TELEPHONE #

DEPENDENT CARE EXPENSE CLAIMS

The following information is ***REQUIRED***: Provider's Tax ID (or SSN) and Business Name; dates of service and the amount of expense; either a receipt/bill ***OR*** your Provider's Signature below.

Name of Dependent(s)	Period Covered From	Period Covered To	Name, Address and Tax ID of Service Provider	Amount to be Reimbursed
			TOTAL DEPENDENT CARE EXPENSE CLAIM	

Signature of Dependent Care Provider | Provider's Tax ID or SSN

UNREIMBURSED MEDICAL/ DENTAL CLAIMS

Attach copies of bills, receipts, Explanation of Benefits (EOBs) or other claim documentation. Documentation must show date of service, description of service and the amount of expense.

DATE OF SERVICE (Mo/Day/Year)	**PROVIDER OF SERVICE** (Name of Doctor, Lab, etc.)	**SERVICE RENDERED** (Office Visit, X-ray, etc.)	**PATIENT NAME**	**CHARGES**

I certify these expenses incurred during my coverage period by me, my spouse or by an individual who qualifies as my dependent for federal income tax purposes. I also certify that these expenses have not been reimbursed from this benefit plan or any other health plan coverage. I further certify that these expenses have not, and will not, be claimed as a tax deduction or credit.

EMPLOYEE'S SIGNATURE | **DATE**