Flexible Spending Account Request for Reimbursement

Group Name: _____ **Date:** _____

Employee Name: _____

Optional Information (For administrator use in case of questions)**:**

Address: _____

Daytime Phone Number: _____

Please attach a copy of your Explanation of Benefits/Detailed Invoice/Detailed Receipt in order to qualify for reimbursement. Documentation must include the following:

***Patient Name**
***Provider Name**
***Date of Service**
***Description of Service or Item**
***Amount of Service or Item**

Date of Service	Name of Patient	Physician or Provider Name	Amount Requested
			$
			$
			$
			$
		Total Amount Requested	**$**

Employee Statement

I certify that the expenses listed above have been incurred by me and/or my eligible dependents and qualify for reimbursement. I have not and will not be reimbursed through any other health plan coverage. I understand that reimbursement is not a guarantee that this payment is tax free. I hereby authorize payment of these expenses from my flexible spending account.

_____ _____

Employee's Signature Date

Please return claim form and EOBs to:
The Benecon Group * Attn: CDH Services
PO Box 5406 * Lancaster, PA 17606-5406
Phone: (833) 738-6729 * Fax: 888-965-3629
CDHServices@benecon.com