



# Health FSA Reimbursement Request Form

Submit claims to: Professional Benefits Services or Fax (616) 285-9965  
 Flexible Spending Department Total number of pages \_\_\_\_\_  
 2959 Lucerne SE, Suite 205  
 Grand Rapids, MI 49546 or Email claims to:  
[flex@professionalbenefits.net](mailto:flex@professionalbenefits.net)

For questions please call: (616) 285-2480 or (800) 732-3412

### Employee Instructions:

1. Reimbursement form must be complete and clear. Failure to answer any questions or provide proper documentation may delay payment.
2. All receipts must have name of dependent, date of service, type of service, a provider, and the amount of the charge.
3. Attach a copy of Explanation of Benefits (EOB) or itemized statement for services you have incurred, and are requesting reimbursement for (Deductibles and copays).
4. Attach paid receipts for eligible expenses not covered by group health plans. Cancelled/Copied checks will not be accepted.
5. Note: If the plan has a Grace Period, then the funds from the prior plan year must be used before current plan funds.

Employer\Place of Employment: **Charlotte Public Schools** Department \_\_\_\_\_

Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Change of Address

Employee Number \_\_\_\_\_ or Social Security Number (Optional) \_\_\_\_\_

Name of person receiving service	Relationship to insured	Service date	Amount of reimbursement requested
1. _____	_____	_____	\$ _____
2. _____	_____	_____	\$ _____
3. _____	_____	_____	\$ _____
4. _____	_____	_____	\$ _____
5. _____	_____	_____	\$ _____
6. _____	_____	_____	\$ _____
7. _____	_____	_____	\$ _____
<b>TOTAL REIMBURSEMENT REQUESTED</b>			<b>\$ _____</b>

To the best of my knowledge and belief, this Reimbursement Request Form is complete and true. I certify that my family member or myself received the services described above on the date indicated and that the expenses qualify as a valid medical service under the Plan. If the expense is for my spouse or dependent, I certify that the person's receipt(s) meets the definition of dependent\spouse in the plan. I certify that I have not been reimbursed previously for these expenses under the Health Reimbursement Plan or any other health plan. I understand that these expenses may not be used to claim any federal income tax deduction or credit.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_