



8220 Irving Road
 Sterling Heights, MI 48312
 PH# 800-645-9978 FAX# 586-693-4321

Flexible Spending Account / Health Care Reimbursement Account

Please print or type. Completed form must be sent in with itemized bills and the Explanation of Benefits (EOB).

| | | |
|----------------------|-------------------------------|------------------------|
| EMPLOYEE NAME | SOCIAL SECURITY NUMBER | EMPLOYER |
| | | Wayne State University |

| | |
|-----------------|-------------------------------------|
| Patient: | Relationship to Participant: |
|-----------------|-------------------------------------|

| Incurred Dates From - To | Provider | Proof of Expense Attach copy--See reverse side for explanation Check One | | Dollar Amount |
|-----------------------------|----------|--|---------------------------------------|---------------|
| | | <input type="checkbox"/> Insurance Statement | <input type="checkbox"/> Bill/Receipt | |
| | | <input type="checkbox"/> Insurance Statement | <input type="checkbox"/> Bill/Receipt | \$ |
| | | <input type="checkbox"/> Insurance Statement | <input type="checkbox"/> Bill/Receipt | \$ |
| | | <input type="checkbox"/> Insurance Statement | <input type="checkbox"/> Bill/Receipt | \$ |
| | | <input type="checkbox"/> Insurance Statement | <input type="checkbox"/> Bill/Receipt | \$ |
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| | | <input type="checkbox"/> Insurance Statement | <input type="checkbox"/> Bill/Receipt | \$ |
| | | <input type="checkbox"/> Insurance Statement | <input type="checkbox"/> Bill/Receipt | \$ |

TOTAL EXPENSE ON THIS REQUEST \$

I certify that the amounts herein requested for reimbursement have been actually incurred as qualified expenses during a period while the undersigned was covered under the plan and have not, cannot and will not be reimbursed from any other benefit plan deducted on my income tax return, nor were they previously submitted for reimbursement under this Plan. I agree to provide supplemental information to process this claim as requested by the Plan Administrator. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim.

| | | |
|---------------------------|---------------------|-------------|
| EMPLOYEE SIGNATURE | PHONE NUMBER | DATE |
| | | |

PROOF OF EXPENSE-REQUIRED DOCUMENTATION

| TYPE OF EXPENSE | Attached Required |
|---|---|
| DEDUCTIBLES Health Plan Deductibles or Other Out-of-Pocket Expenses | Explanation of Benefits (EOB) statement must be submitted if claims is covered but not paid by any plan (i.e. the amount you must pay out-of-pocket because of deductibles or coinsurance. |
| Health Expenses Not Covered by Insurance | Itemized bills from the doctor, dentist or other provider of qualifying expenses when the claim being submitted is not covered by any plan (i.e. physical exams, hearing aids, glasses, etc). |
| Co-Payment | Copy of the co-payment receipt from the provider when the co-payment is your only cost and you do not receive an EOB. |
| Prescription Drugs | Must be itemized. Cash register receipts are not accepted. |

NOTE: Itemized bills must include the patient name, name/address of the provider, date services were incurred, description of the expense, and charges. Claims eligible for insurance coverage must be filed with the insurance company first. The insurance company explanation of benefits may be submitted for Flex reimbursement. In this circumstance, a copy of the bill may not be necessary.