2019
HRA/MEDICAL REIMBURSEMENT VOUCHER

Send completed Voucher to:
M.A. Services Claims Center
PO Box 587
Pittsford, NY 14534
PHONE: 800-836-8100
FAX: 585-248-2488

Please read these instructions prior to completing the Reimbursement Voucher:

1. **Please complete all of the required information below. Attach additional sheets if necessary.**
2. **Attach corresponding bills, receipts, necessary documentation that includes the provider of service, date of service, type of service, recipient of service and any insurance payments made on the claim.**
3. **Read employee statement and sign and date the Reimbursement Voucher.**
4. **Mail to the address above, fax to 585.248.2488, or email to info@flexbene.com.**

Failure to submit a properly prepared Reimbursement Voucher could result in a delay in the process of your reimbursement request.

For Admin use only:
Amt Approved:
$________________
Amt Denied:
$________________
Date: ____________

Part I: Employee Information

Employer:		**Department:**
Employee Name:		**Employee SSN:** XXX-XX-___ ___ ___ ___
Daytime Phone:	**Email Address:**	**May we contact you via email?** ☐ Yes ☐ No

Part II: Unreimbursed Medical Expenses

Date of Service	Type of Service Please check the appropriate box for each expense **MD**=medical **RX**=prescription	Recipient of Service	Service or Medicine Name	Diagnosis or Condition	Amount Requested
	☐ MD ☐ RX				
	☐ MD ☐ RX				
	☐ MD ☐ RX				
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	☐ MD ☐ RX				
	☐ MD ☐ RX				
	☐ MD ☐ RX				
	☐ MD ☐ RX				
		Unreimbursed Medical Total:			**$**

To the best of my knowledge and belief, my statements in this Reimbursement Voucher are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for the eligible plan participants. I certify that these expenses have not been previously reimbursed by this or any other benefit plan and WILL NOT BE CLAIMED AS AN INCOME TAX DEDUCTION.
I AUTHORIZE MY FLEXIBLE BENEFITS ACCOUNT TO BE REDUCED BY THE AMOUNT REQUESTED.

EMPLOYEE SIGNATURE: ____ **DATE:** ________________

If you have any questions regarding this Reimbursement Voucher or your account please contact us at:
585.385.6010 or 800.836.8100 or info@flexbene.com