Plan Year: _____
Flexible Benefits
Reimbursement Vouch

PO Box 587
Pittsford, NY 14534
Fax: 585-248-2488
Email: info@flexbene.com

Please read these instructions prior to completing the Reimbursement Voucher:	Admin Use Only:
1. Please complete all required information below. Attach additional vouchers 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 claim. 3. For Dependent Care please indicate dates of service on Dependent Day Care Calendar. 4. **ONLY Date of Service is eligible, "Payment Date" and "Balance Forward" is NOT eligible.** 5. Read employee statement, sign, and date the Reimbursement Voucher. **Failure to submit a properly prepared Reimbursement Voucher AND documentation could result in a delay and/or denial in the process of your reimbursement**	Amt Approved: $_____ Amt Denied: $_____ Date: _____

Part I: Employee Information

EMPLOYER:	Department:
EMPLOYEE:	Employee SSN: X X X – X X –___ ___ ___ ___

Daytime Phone:	Email Address:	May we contact you via email? ☐ Yes ☐ No

Part II: Unreimbursed Medical, Dental, Vision Expenses

Date of Service	Type of Service Please check the appropriate box for each expense MD=medical RX=prescription VS=vision DN=dental OT=other	Recipient of Service	Service OR Medicine Name	Diagnosis or Condition	Amount Requested
	☐ MD ☐ RX ☐ VS ☐ DN ☐ OT				
	☐ MD ☐ RX ☐ VS ☐ DN ☐ OT				
	☐ MD ☐ RX ☐ VS ☐ DN ☐ OT				
	☐ MD ☐ RX ☐ VS ☐ DN ☐ OT				
	☐ MD ☐ RX ☐ VS ☐ DN ☐ OT				
	☐ MD ☐ RX ☐ VS ☐ DN ☐ OT				
	☐ MD ☐ RX ☐ VS ☐ DN ☐ OT				
	☐ MD ☐ RX ☐ VS ☐ DN ☐ OT				
	☐ MD ☐ RX ☐ VS ☐ DN ☐ OT				
	☐ MD ☐ RX ☐ VS ☐ DN ☐ OT				
	☐ MD ☐ RX ☐ VS ☐ DN ☐ OT				
	☐ MD ☐ RX ☐ VS ☐ DN ☐ OT				
	☐ MD ☐ RX ☐ VS ☐ DN ☐ OT				
			Unreimbursed Medical Subtotal:		$

Part III: Child Care, Eligible Dependent Day Care Expenses

(Please Note: a current Dependent Care Registration Form must be on file for provider listed for reimbursement)

Dependent	Date of Birth	Provider	Date(s) of Service MM/DD/YYYY		Amount Claimed
			From:	To:	
			From:	To:	
			From:	To:	
				Dependent Day Care Subtotal:	$
				Total Amount Requested:	$

Employee Statement: 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:
800.836.8100 or info@flexbene.com