FLEXIBLE SPENDING MEDICAL REIMBURSEMENT REQUEST

SUBMIT CLAIMS TO : MUTUAL HEALTH SERVICE
P.O. BOX 5700
MZ: 04-2W-8610
CLEVELAND, OHIO 44101

phone (330)666-0337 toll free 800-367-3762 ext 14535
fax (330)666-2845 flex@mutualhealthservices.com

EMPLOYEE INSTRUCTIONS

1. COMPLETE PARTS A & B IN FULL
2. ATTACH COPY OF EXPLANATION OF BENEFITS (EOB's) FOR DEDUCTIBLE AND COINSURANCE REIMBURSEMENT REQUESTS
3. ATTACH ITEMIZED BILLS FOR EXPENSES NOT COVERED BY MEDICAL/DENTAL INSURANCE
4. ALL REQUESTS FOR OVER-THE-COUNTER MEDICATIONS MUST BE ACCOMPANIED BY A RECEIPT OF PURCHASE SHOWING THE DATE PURCHASED, THE AMOUNT PAID AND THE NAME OF THE PRODUCT ALONG WITH A PRESCRIPTION FROM YOUR PHYSICIAN

PART A FAILURE TO ANSWER ALL QUESTIONS MAY CAUSE DELAY IN PAYMENT

ADDRESS CHANGE ? (PLEASE CIRCLE) YES NO

EMPLOYEE NAME (FIRST, MIDDLE, LAST)	STREET ADDRESS	CITY	STATE	ZIP CO

DATE OF BIRTH	EMPLOYER	SOCIAL SECURITY NUMBER

DEPENDENT NAMES	SEX (PLEASE CIRCLE)		RELATIONSHIP TO EMPLOYEE
1	MALE	FEMALE	
2	MALE	FEMALE	
3	MALE	FEMALE	
4	MALE	FEMALE	
5	MALE	FEMALE	

PART B REIMBURSEMENT REQUEST

1. DEDUCTIBLE & COINSURANCE EXPENSES $_____
2. EXPENSES NOT COVERED BY INSURANCE $_____
3. OVER-THE-COUNTER(OTC) EXPENSES $_____

TOTAL REIMBURSEMENT REQUEST $_____

I HEREBY REQUEST THAT THE EXPENSES SHOWN ABOVE BE CONSIDERED FOR PAYMENT. I CERTIFY THAT THESE EXPENSES ARE NOT ELIGIBLE FOR PAYMENT UNDER ANY INSURANCE PLAN. I UNDERSTAND THAT AN EXPENSES REIMBURSED CANNOT BE USED FOR TAX DEDUCTIONS ON MY FEDERAL INCOME TAX RETURN.

_____ _____/_____/_____

EMPLOYEE SIGNATURE DATE

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