

FLEXIBLE SPENDING MEDICAL REIMBURSEMENT REQUEST



**MUTUAL
HEALTH SERVICESSM**

SUBMIT CLAIMS TO : **MUTUAL HEALTH SERVICES**
P.O. BOX 5700
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****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 CODE

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 ANY EXPENSES REIMBURSED CANNOT BE USED FOR TAX DEDUCTIONS ON MY FEDERAL INCOME TAX RETURN.

_____	____/____/____
EMPLOYEE SIGNATURE	DATE

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