Flexible Spending Account
Request for Reimbursement
CLAIM FORM

Employer Name:			
Employee Name:	Last First	**SS#**	
Employee Address:	Street City State ZIP	**PHONE**	( )
Email Address:			

☐ **Please check if this is a new address**

Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this claim.

* Information below must be completed

MEDICAL EXPENSE CLAIMS

Date of Service MM/DD/YY	Patient Name	Patient's SS#	Relationship	Name of Provider	Description of Service	Claim Amount
						$
						$
						$
						$
						$
						$
						$
						$
						$
				Total:		$

DEPENDENT CARE CLAIMS

Date of Service From	To	Dependent Name	Age	Dependent Care Provider Name	Dependent Care Provider Address	Provider Tax Id#/SS#	Claim Amount
							$
							$
							$
							$
						Total:	$

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ Date: _____ /_____ /_____

FOR FASTEST REIMBURSEMENT, FAX TO: 501.687.3282 OR TOLL FREE 1.888.472.6777

EMAIL TO: INFO@IDPAS.COM

OR MAIL TO:

DATAPATH ADMINISTRATIVE SERVICES

1601 WESTPARK DRIVE SUITE 9, LITTLE ROCK, AR 72204