

Health Care Expense Reimbursement Form

Employer: Oswego County Opportunities

- TIPS TO ASSIST REIMBURSEMENT PROCESSING:**
- ✓ Print all information
 - ✓ Keep a copy of the reimbursement form and all receipts
 - ✓ Make copies of this form to use for future claims

Employee Information

Last Name _____ First Name _____ MI _____ Last 4-digits Social Security # _____

New Address

Mailing Address _____ City/State _____ Zip _____ Daytime Phone _____

Reimbursement Information Requirements

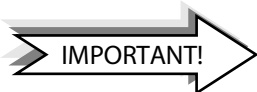
Receipts must include: Patient's Name Date of Service
 Provider's Name Type of Service (Procedure Codes), and Amount.

Each receipt must be listed below.

DATE OF SERVICE	PERSON RECEIVING SERVICES	TYPE OF SERVICE	AMOUNT
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/Name _____ <input type="checkbox"/> Child/Name _____	<input type="checkbox"/> Dr Visit <input type="checkbox"/> Rx <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Over-the-Counter Item <input type="checkbox"/> Other	\$ _____
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/Name _____ <input type="checkbox"/> Child/Name _____	<input type="checkbox"/> Dr Visit <input type="checkbox"/> Rx <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Over-the-Counter Item <input type="checkbox"/> Other	\$ _____
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/Name _____ <input type="checkbox"/> Child/Name _____	<input type="checkbox"/> Dr Visit <input type="checkbox"/> Rx <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Over-the-Counter Item <input type="checkbox"/> Other	\$ _____
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/Name _____ <input type="checkbox"/> Child/Name _____	<input type="checkbox"/> Dr Visit <input type="checkbox"/> Rx <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Over-the-Counter Item <input type="checkbox"/> Other	\$ _____
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/Name _____ <input type="checkbox"/> Child/Name _____	<input type="checkbox"/> Dr Visit <input type="checkbox"/> Rx <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Over-the-Counter Item <input type="checkbox"/> Other	\$ _____
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/Name _____ <input type="checkbox"/> Child/Name _____	<input type="checkbox"/> Dr Visit <input type="checkbox"/> Rx <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Over-the-Counter Item <input type="checkbox"/> Other	\$ _____
✓ All information must be completed in order to process your reimbursement.			TOTAL \$ _____

I have attached originals or LEGIBLE copies of supporting documents, such as receipts and statements (EOB's from the insurance company as to the uninsured part of the expense). **No expenses submitted for reimbursement are eligible for payment from any health and/or dental plan under which I, my spouse, and/or dependents are covered.** I understand that expenses for my spouse and tax dependent child(ren) are only eligible for reimbursement if I completed a Dependent Enrollment form for "family" coverage. I understand that I cannot deduct such costs as expenses on my individual Federal and State Income Tax Returns.

I certify that the above information is correct and complete and I have not submitted a previous request for these expenses.



Signature: _____

Date: _____

IMPORTANT—All reimbursement forms must be completely filled out with dates of service, type of service and amounts you are claiming. They must be signed, dated and include the last 4-digits of your Social Security Number. If the form is not complete, it will be returned to you for completion. Reimbursement paperwork must be sent to the address/fax noted below and will be reimbursed on the next processing cycle.

Send reimbursement requests to:

Flexible Benefits System
 PO Box 549
 Pittsford, NY 14534
 (PH—800-622-6233)

OR

Flexible Benefits System
 (FAX —585-641-7500)

DO NOT send Originals, if faxed.

FBS Internal Use Only

___/___/___

___/___/___

Rev. 9.15.10 | FBS