PLEASE MAKE COPIES OF THIS FORM FOR FUTURE CLAIMS

MEDICAL
REIMBURSEMENT REQUEST FORM

(For Health Care Reimbursement Account (HCRA) Qualifying Medical Expenses)

NOTE: This form MUST be completed to receive reimbursement for out-of-pocket medical expenses for your Flexible Spending Account(s). These services MUST have been incurred during the current Plan Year. **An itemized copy of the provider's itemized bill or your insurance company's "Explanation of Benefits" verifying the date and the cost of service MUST be attached to this form.** *Your claim will not be processed until these items are received by MGIS.* ***Credit card receipts or cancelled checks cannot be accepted.***

FAX COMPLETED FORM AND ALL DOCUMENTATION TO:

MEDICAL GROUP INSURANCE SERVICES, INC.
CLAIMS FAX: 866.969.4446

PLEASE COMPLETE ENTIRE FORM. PRINT OR TYPE (USE ADDITIONAL SHEETS IF NECESSARY)

EMPLOYER NAME:	**PLAN YEAR:**
EMPLOYEE NAME: _____ (LAST / FIRST / MI)	**SOCIAL SECURITY NUMBER:** _____-_____-_____
EMPLOYEE HOME ADDRESS: _____ (NUMBER AND STREET) _____ (CITY) _____ (STATE) _____ (ZIP)	
❑ **CHECK HERE IF THIS IS A CHANGE IN ADDRESS**	
EMPLOYEE DAY PHONE: ( )	**EMPLOYEE E-MAIL:**
INDICATE WHICH COVERAGES YOU HAVE: (CHECK ALL THAT APPLY) ❑ MEDICAL ❑ DENTAL ❑ VISION	**IS A SPOUSE AND/OR DEPENDENT INCLUDED UNDER THIS COVERAGE?:** (CHECK ONE) ❑ YES ❑ NO

UNREIMBURSED MEDICAL EXPENSES

(QUALIFYING MEDICAL EXPENSE FOR YOU OR ANY TAX DEPENDENT)

See IRC Section 213 for qualifying Healthcare expenses or consult your tax advisor for more information.

DATED EXPENSE INCURRED (MM/DD/YY)	SERVICE PROVIDER (clinic, pharmacy, doctor, store, etc.)	DESCRIPTION OF EXPENSE	RELATION TO PARTICIPANT	AMOUNT PAID BY INSURANCE (IF ANY)	AMOUNT PAID BY YOU	AMOUNT PAID (TOTAL EXPENSE)
Credit card receipts or cancelled checks cannot be accepted.						
				TOTAL REQUESTED REIMBURSEMENT AMOUNT	$	

To the best of my knowledge and belief, my statements on this Request for Reimbursement are complete and true. I understand that I am solely responsible for the validity of claims submitted to my Flexible Spending Account and/or Health Care Reimbursement Account. I am claiming reimbursement only for eligible expenses incurred by myself, spouse and/or covered dependents (for FSA reimbursement, these expenses must have been incurred during the Plan Year shown above) and certify that these expenses have not been reimbursed under this Plan or by any other source and that they will not be reimbursed by any other source or insurance. I hereby authorize my Flexible Spending Account to be reduced by the amount(s) shown above.

PARTICIPANT'S SIGNATURE X _____ DATE _____

If you have questions or need assistance, call the number listed below or visit our website.