



LPFSA REIMBURSEMENT REQUEST FORM

(Vision and Dental Expenses Only)
(For Limited Purpose Flexible Spending Account [LPFSA])

NOTE: This form **MUST** be completed to receive reimbursement for out-of-pocket **vision** and **dental** expenses only from your Limited Purpose Flexible Spending Account. 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: _____ <small>LAST FIRST MI</small>		SOCIAL SECURITY NUMBER: _____ - _____ - _____	
EMPLOYEE HOME ADDRESS: _____ <small>NUMBER AND STREET CITY STATE ZIP</small>			
EMPLOYEE DAY PHONE: () _____		EMPLOYEE E-MAIL: _____	
INDICATE WHICH COVERAGES YOU HAVE: (CHECK ALL THAT APPLY)		IS A SPOUSE AND/OR DEPENDENT INCLUDED: UNDER THIS COVERAGE?: (CHECK ONE)	
<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION		<input type="checkbox"/> YES <input type="checkbox"/> NO	

UNREIMBURSED EXPENSES
(QUALIFYING VISION OR DENTAL EXPENSES FOR YOU OR ANY TAX DEPENDENT)

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

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