HRA/MEDICAL REIMBURSEMENT VOUCHER

Send completed Voucher to:
M.A. Services Claims Center
PO Box 587
Pittsford, NY 14534
FAX: 585.424.2910

Please read these instructions prior to completing the Reimbursement Voucher:

1. **Please complete all of the required information below. Attach additional sheets if necessary.**
2. **Attach corresponding bills, receipts, necessary documentation that includes the provider of service, date of service, type of service, recipient of service and any insurance payments made on claim.**
3. **Read employee statement and sign and date the Reimbursement Voucher.**
4. **Mail to the address above, fax to 585.424.2910, or email to info@flexbene.com.**

Failure to submit a properly prepared Reimbursement Voucher could result in a delay in the process of your reimbursement request.

Part I: Employee Information

Employer:	**Department:**	
Employee Name:	**Employee SSN:** **XXX-XX-___ ___ ___ ___**	
Daytime Phone:	**Email Address:**	**May we contact you via email?** ☐ **Yes** ☐ **No**

Part II: Unreimbursed Medical Expenses

Date of Service	Type of Service Please check the appropriate box for each expense **MD**=medical **RX**=prescription	Recipient of Service	Service or Medicine Name	Diagnosis or Condition	Amount Requested
	☐ **MD** ☐ **RX**				
	☐ **MD** ☐ **RX**				
	☐ **MD** ☐ **RX**				
	☐ **MD** ☐ **RX**				
	☐ **MD** ☐ **RX**				
	☐ **MD** ☐ **RX**				
	☐ **MD** ☐ **RX**				
	☐ **MD** ☐ **RX**				
	☐ **MD** ☐ **RX**				
	☐ **MD** ☐ **RX**				
	☐ **MD** ☐ **RX**				
	☐ **MD** ☐ **RX**				
		Unreimbursed Medical Total:			**$**

To the best of my knowledge and belief, my statements in this Reimbursement Voucher are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for the eligible plan participants. I certify that these expenses have not been previously reimbursed by this or any other benefit plan and WILL NOT BE CLAIMED AS AN INCOME TAX DEDUCTION.

I AUTHORIZE MY FLEXIBLE BENEFITS ACCOUNT TO BE REDUCED BY THE AMOUNT REQUESTED.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

If you have any questions regarding this Reimbursement Voucher or your account please contact us at:
585.730.8044 or 800.836.8100 or info@flexbene.com