2019
Medical / HRA
Reimbursement Voucher

Send completed Voucher to:
M.A. Services Claims Center
PO Box 587
Pittsford, NY 14534
FAX 585-248-2488

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. In addition, for Dependent Care please indicate dates of service on reverse.**
3. **Read employee statement and sign and date the Reimbursement Voucher.**
4. **Mail to the address above, fax to 585.248.2488, 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.

For Admin use only:
Amt Approved:
$_____
Amt Denied:
$_____
Date: _____

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, Dental, Vision Expenses

Date of Service	Type of Service Please check the appropriate box for each expense **MD**=medical **RX**=prescription **VS**=vision **DN**=dental **OT**=other	Recipient of Service	Service or Medicine Name	Diagnosis or Condition	Amount Requested
	☐ **MD** ☐ **RX** ☐ **VS** ☐ **DN** ☐ **OT**				
	☐ **MD** ☐ **RX** ☐ **VS** ☐ **DN** ☐ **OT**				
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	☐ **MD** ☐ **RX** ☐ **VS** ☐ **DN** ☐ **OT**				
	☐ **MD** ☐ **RX** ☐ **VS** ☐ **DN** ☐ **OT**				
		Total Amount Requested:			**$**

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:
800.836.8100 or info@flexbene.com