

Flexible Spending Account Request for Reimbursement



Company: Wicomico County Public Schools

Plan Year: 9.1.08 – 8.31.09

4Z Wicomico Sch

Employee First Name	Employee Last Name
First 5 digits of Employee ID No.	Daytime Phone #
Home Address <input type="checkbox"/> Check here if new address	
E-Mail Address <input type="checkbox"/> Check here if new address	

Unreimbursed Medical Expenses				
	Date(s) of Service	Physician or Other Provider	Expense Amount	
<ul style="list-style-type: none"> Complete this section for unreimbursed qualified medical expenses incurred by you, your spouse or dependent. Attach receipt, statement or insurance carrier Explanation of Benefits (EOB) for each item listed. Receipt/statement /EOB must list: <ul style="list-style-type: none"> Provider name Date(s) of service (s) Description of service(s) Your portion of the cost Expenses are reimbursable based on date the service occurred and not when you pay for, or are billed for the service. For vitamins or supplements, submit receipt and doctor's note stating the specific medical condition being treated and recommending the specific vitamin or supplement for treatment of that condition. The note should also state if the vitamin or supplement is to be taken for a limited time or indefinitely. Canceled checks are not sufficient as proof of an incurred expense. 				
	Total Amount Requested			

Dependent Care Expenses				
	Date(s) of Service	Provider	Expense Amount	
<ul style="list-style-type: none"> Complete this section for unreimbursed qualified dependent care expenses which were incurred so that you (and if married, your spouse) can work. Attach a receipt or statement from your dependent care provider <u>or have your provider sign below.</u> Your receipt or statement must list: <ul style="list-style-type: none"> Provider's name Date(s) of service (s) Description of service(s) Your portion of the cost Prepaid expenses cannot be reimbursed until the services have occurred. You will need the provider's name, address, SS# or TIN when you file your Form 2441 with your 1040 at tax time. Canceled checks are not sufficient as proof of an incurred expense. 				
	Total Amount Requested			

Dependent Care Provider Signature (If no receipt is provided)	
I certify that the above listed Dependent Care charges have been incurred.	
Provider Signature	Date

Participant Statement	
<p>I certify that the expenses listed above have been incurred by me, my spouse and/or my eligible dependents during the plan year and while I was a participant in the plan. To the best of knowledge all expenses listed above are eligible for reimbursement under the plan. I certify that any prescription drug expenses submitted are for medical care and not cosmetic purposes (e.g., Propecia for male pattern baldness, Retin-A for smoothing wrinkles, etc.). I understand that I am responsible for the accuracy of the information related to this request. I have not and will not seek to be reimbursed through any other health plan coverage and/or dependent care assistance plan for any of the expenses listed above. I further declare I will not deduct any of the reimbursed medical expenses listed above from my federal, state or local tax returns.</p>	
Participant signature	Date

Please email, mail or fax claim forms to:
 claims@hfsbenefits.com
 Claims Department, HFS
 P.O. Box 1550, Hunt Valley, MD 21030-1550
 Phone: 410.771.1331 / Toll Free: 888.460.8005
 Fax: 410.771.5533 / Toll Free 888.510.4218
 ****PLEASE DO NOT MAIL ORIGINALS****