

**Health Care Flexible Spending (FSA)
Reimbursement Form**



PARTICIPANT INFORMATION			
ID NUMBER OR SSN	LAST NAME	FIRST NAME	M.I.
EMPLOYER NAME UNITED STATES ENRICHMENT (G)		EMPLOYER ID/CLIENT CODE L02708	

HELPFUL TIPS

- Make copies of your supporting documentation. Submit the copies and retain the originals for your records. Please do not highlight items or staple receipts.
- Each expense must be accompanied by its receipt and/or Explanation of Benefits (EOB) from your insurance company showing Date of Service, Amount of Service, Provider and Type of Service (DAPT).

STEP #1 – Complete this section

<ul style="list-style-type: none"> • Date of Service (enter date service was incurred) • Type of Service (use the codes in the box to the right) • Description of service (you may use drug name or Rx number) • Miles (to be reimbursed for mileage expenses, write the number of miles driven to and from the provider; enter each trip once) • Tax (enter the amount of sales tax charged for each item) • Amount of service or item • Total Amount (include amount and tax) 	<p align="center">Type of Service Codes:</p> <p>MED: Medical VIS: Vision DEN: Dental OTC: Over-the-counter RX: Pharmacy ORTHO: Orthodontia</p>
--	--

Each expense is reviewed to determine eligibility under the plan. If the amount you request below exceeds the amount of eligible expenses listed on your supporting documentation, you will be reimbursed the eligible amount. You will be reimbursed only for the eligible expenses itemized on the form.

DATE OF SERVICE	TYPE OF SERVICE	DESCRIPTION	MILES (Optional)	TAX (Optional)	AMOUNT	TOTAL AMOUNT
				\$	\$	\$
				\$	\$	\$
				\$	\$	\$
				\$	\$	\$
				\$	\$	\$

Please submit additional signed form(s) if more space is required.

TOTAL AMOUNT REQUESTED	\$
-------------------------------	----

STEP #2 – Sign the form

By submitting this form, I attest and agree to the following: To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable coverage period for myself and/or my legal dependent(s) under the plan. I certify that these expenses have not previously been reimbursed or will not be reimbursed under any other benefit plan, and will not be claimed as an income tax deduction.

EMPLOYEE SIGNATURE <i>(Required)</i> X	DATE
---	------

STEP #3 – Make copies of the supporting documentation

STEP #4 – Submit signed form(s) and copies of supporting documentation

Fax to: 1-866-717-3820 (Please do not use a cover sheet)

Mail claims with documentation to: REIMBURSEMENT ADMINISTRATION, PO BOX 534451, ST PETERSBURG, FL 33747
 For Customer Service, please call: **1-877-799-8820**

Caution: Form contains personalized encoded information. Do not share with others.