

## EMPLOYEES' FLEXIBLE BENEFITS PROGRAM CLAIM FORM

EXPENSE REIMBURSEMENT FORM – **MEDICAL / DENTAL** SPENDING ACCOUNT

(Use this form **only** for medical, dental and/or prescription drug expenses **not** reimbursed by your company's Major Medical or Dental Insurance programs)

Employer Name: \_\_\_\_\_

Employee: \_\_\_\_\_ SS # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**CLAIM INFORMATION**

Patient Name	Provider Name (Doctor/pharmacy)	Service Dates From: To:	Type of Service (Office Visit, Rx, OTC)	Claim Amount
1.		From: To:		
2.		From: To:		
3.		From: To:		
4.		From: To:		
5.		From: To:		
<b>Notes:</b>			<b>Total:</b>	<b>\$</b>

**Attach all bills or itemized paid receipts**

**Attach a copy of insurance company's payment or denial if applicable**

In submitting this claim, I certify that these expenses have not been reimbursed and are not reimbursable under my major medical plan or any other plan. I also understand this claim is for medical care as defined by the Internal Revenue Code § 213(d)(1). This code defines "medical care" to include amounts paid for diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. I understand that the expense for which I am reimbursed may not be used to claim any federal income tax deduction or credit.

\_\_\_\_\_  
*Signature of Employee*

\_\_\_\_\_  
*Date*

**SUBMIT CLAIM  
TO:**

GMR Administrative Services  
PO Box 24369  
Rochester, NY 14624-0369  
(800) 724-4817 Fax (585) 426-6981

