

FSA Reimbursement Request Form



Instructions: Please print or type and complete all items under **Personal Information**. In order to receive reimbursement, you must submit an *Explanation of Benefits Statement* (if applicable) from your insurance carrier, or an itemized statement that includes the provider name, patient name, date of service, description of service, insurance responsibility (if applicable), and patient responsibility for each health care claim. For dependent care reimbursement you have two choices: (1) Fill out all items in the **Dependent Care Expenses** section and attach a receipt of your payment, **OR** (2) Fill in your dependent's name, age, date of service and the requested amount, and have your Day Care provider fill out the **Affidavit of Dependent Care Provider**. You must sign and date this form and attach any corresponding receipts in order for us to process this claim. You have permission to photocopy this form.

PERSONAL INFORMATION	
Employer's Name	Email Address
Employee's Name	Date of Request
Employee's Social Security Number	Daytime Phone Number

HEALTH CARE EXPENSES					
Patient Name	Relationship	Age	Date of Service	Type of Service (Medical, Dental, etc.)	Requested Amount
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
				Total:	

DEPENDENT CARE EXPENSES				
Dependent's Name	Age	Date of Service		Requested Amount
		From	To	
1.				
2.				
3.				
			Total:	

email, fax or mail form to: claims@americanbenefitadministrators.com
 Toll Free Fax (866) 734-4777
 246 Inverness Center Parkway, Birmingham, Alabama 35242
 Toll Free Customer Service (866) 742-4900
www.americanbenefitadministrators.com

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AFFIDAVIT OF DEPENDENT CARE PROVIDER

I have provided adult/child care for _____, age _____, for the period beginning _____ and ending _____. Services were provided by _____ for a fee of \$_____.

Signature of Provider

Tax ID# or SS

Date

I, the undersigned, hereby certify that the above listed expenses have not been previously reimbursed from my Flexible Spending Account, nor are reimbursable from any other source. I hereby authorize American Benefit Administrators, LLC. to obtain necessary information from all physicians, hospitals, daycare providers, employers and all other agents in order to adjudicate the claim for reimbursement under the Benefit Plan established by my employer.

Employee Signature

Date