

## **IMPORTANT INFORMATION ON COMPLETING YOUR REIMBURSEMENT FORM**

**In order to avoid delay in processing of your claims or in having part of your claim denied, please read and follow the instructions below.**

- 1) Complete Section 1 of the Reimbursement Form providing all requested information.**

**Because space is limited on the form, if you are informing us of a change of address, it is very helpful if you highlight, put an \*\* or a large ✓ check in the box provided in order for us to not overlook.**

- 2) Complete Section 2 for reimbursement of Medical Care receipts you are submitting.**

### **IMPORTANT:**

**Requests for reimbursement of claims must contain the following information:**

- a) Vendors Name** i.e., WalMart, InterMed, Jones Dental Services, etc.;
- b) DATE OF SERVICE – THIS MEANS, THE DATE YOU RECEIVED TREATMENT OR DATE YOU PURCHASED THE ITEM, EITHER PERSCRIPTION OR OVER-THE-COUNTER. --IT DOES NOT MEAN DATE OF A STATEMENT.**
- c) Description/Identification** of service or item(s) purchased; and
- d) The \$ amount** you are requesting reimbursement for.

**NOTE:** Canceled Checks are NOT ACCEPTABLE for receipts as per IRS regulations.

- 3) Complete Section 3 for reimbursement of Child Care expenses** paid while you and/or your spouse work. The form must be signed by the child care provider and their social security or identification number provided.

**By completing the “Request for Reimbursement Request Form” correctly, this will help in ensuring your claims are paid out in a timely manner by avoiding delays and/or denials of your claims.**

**Should you have any questions on allowable areas, items, etc. for reimbursement, please do not hesitate to call us toll free at 1-866-655-5397. We will be happy to provide you the information you need.**

**H R Support & Consulting Services Flex Administration  
159 Watkins Shores Road  
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