

# Flexible Spending Account (FSA)

## Unreimbursed Medical Reimbursement Form



**INSTRUCTIONS:** Please type or print the required information. Remember to attach the appropriate Explanation of Benefit (EOB) statements, receipts, or other documents indicating the provider, the patient, and the amount and date of service. If the patient receiving the service is not you, please indicate the relationship (spouse or dependent child). Sign and return a copy of this form to **Integra BMS, Attn: Claims, P.O. Box 1178, Matthews, NC 28106. The phone number for Integra BMS is 1-800-228-1803.**

### SECTION (I) PERSONAL INFORMATION

Last Name	First Name	Middle Name
Member ID	Department / Division	Work Phone Number

### SECTION (II) UNREIMBURSED MEDICAL EXPENSE INFORMATION

Item No.	Date of Expense		Provider of Services	Patient's Name	Patient's Relationship to You	Total Amount Of Expense	Total Amount Paid by Insurance	Amount to be Reimbursed To You
	From	Through						
1						\$	\$	\$
2						\$	\$	\$
3						\$	\$	\$
4						\$	\$	\$
5						\$	\$	\$
6						\$	\$	\$
7						\$	\$	\$
8						\$	\$	\$
<b>TOTAL</b>								\$

### SECTION (III) EMPLOYEE AUTHORIZATION AND SIGNATURE

By my signature below, I request payment from my Unreimbursed Medical Flexible Spending account for the itemized expenses listed above and/or attached to this form. By my signature below, I certify the following:

- I have not been reimbursed under this FSA Plan or from any other source for these expenses;
- I have met all of the requirements for eligible unreimbursed medical expenses as described in the FSA Plan Document and other FSA materials
- The services claimed above were received during the current plan year and while I was an active participant in the Plan;
- The total unreimbursed medical expenses (if any) for which I am requesting reimbursement this Plan Year do not exceed the lessor of my or my spouse's earned income for the year. I understand that reimbursed expenses cannot be claimed as deductions on my personal income tax return. I understand that according to IRS rules, any account balances at calendar year end will be forfeited.

APPLICANT SIGNATURE	DATE
---------------------	------

For processing, please remit this form and any attachments to:

via fax <i>(local in Charlotte, NC)</i>	via email <i>(scan and email as attachment)</i>	via US Mail
1-704-845-5629	claims@integrahealth.com	Integra BMS Attention: Claims P.O. Box 1178 - Matthews, NC 28106