FLEX source, LLC.
Flexible Benefits Specialists

Medical Flexible Spending Account Reimbursement Claim

Please type or print all information

Company Name

Employee Name   Employee Phone Number ( )

Social Security Number

Street Address   City   State   Zip

I certify the information here is true and correct; that the expenses incurred were for myself, spouse; or dependents, that these expenses are not reimbursable under any other health plan coverage; and that these expenses are medically necessary as defined in Internal Revenue Code Section 213.

Employee Signature   Date

Supply Additional Information Below

Member Name	Social Security Number	Relationship to Employee	Amount	Date(s) of Service	Provider of Service	Description	Claim Ref. #
		Self/Spouse Child/Other (Specify)					01
							02
							03
							04
							05
							06
							07
							08

Instructions

1. All receipts must include patient name, date of service, a description of service provided, dollar amount of charges and name & address of service provider.
2. Copies of all bills for reimbursement must be enclosed with claim form.
3. Did you sign your claim form and include your company name?

Note: Regarding faxed claims. Any missing pages or illegible copies will be the responsibility of the sender.

If you have any questions, please contact : FlexSource at (630) 782-0633

Mail to:
FlexSource, LLC
P.O. Box 828
Elmhurst, IL 60126

Fax: (630) 782-0644