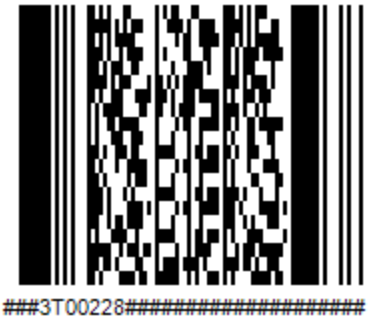
CORE MANAGEMENT RESOURCES

Flexible Spending Account - FSA Reimbursement Request Form

Mail: Core Management Resources
P.O. Box 90
Macon, GA 31202
Fax: 478-750-1705
eFax: 1-855-673-6714



Please print clearly

EMPLOYER _____ PLAN YEAR _____

EMPLOYEE NAME _____ MEMBER ID# or SSN _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____ DAYTIME TELEPHONE # _____

DEPENDENT CARE EXPENSE CLAIMS

The following information is ***REQUIRED***: Provider's Tax ID (or SSN) and Business Name; dates of service and the amount of expense; and a receipt/bill with your Provider's Signature below.

Name of Dependent(s)	Period Covered		Name, Address and Tax ID of Service Provider	Amount to be Reimbursed
	From	To		
			TOTAL DEPENDENT CARE EXPENSE CLAIM	

Signature of Dependent Care Provider _____ Provider's Tax ID or SSN _____

UNREIMBURSED MEDICAL CLAIMS

Attach copies of bills, receipts, Explanation of Benefits (EOBs) or other claim documentation. Documentation must show date of service, description of service and the amount of expense.

DATE OF SERVICE (Mo/Day/Year)	**PROVIDER OF SERVICE** (Name of Doctor, Lab, etc.)	**SERVICE RENDERED** (Office Visit, X-ray, etc.)	**PATIENT NAME**	**CHARGES**

I certify these expenses incurred during my coverage period by me, my spouse or by an individual who qualifies as my dependent for federal income tax purposes. I also certify that these expenses have not been reimbursed from this benefit plan or any other health plan coverage. I further certify that these expenses have not, and will not, be claimed as a tax deduction or credit.

EMPLOYEE'S SIGNATURE _____ **DATE** _____