Send to: Health Cost Solutions
P.O. Box 1439
Hendersonville, TN 37077
Fax: (615) 333-4196

FSA

Flexible Spending Account
HEALTH CARE EXPENSES

Reimbursement Request

Section 1: EMPLOYEE INFORMATION

Name _____ Social Security No. _____
(last) (first) (middle initial)

Location _____ Daytime Phone No. _____

Home Address _____
(Street) (City) (State) (Zip Code)

Marital Status _____

Documentation must be provided and will not be returned. Copies should be made prior to submission. Attach copies of statements or Explanation of Benefits (EOB) from BC/BS showing:

- Description of the service or supply (including name of provider)
- Date that service or supply was received (mm/dd/yy)
- Amount of the expense and any adjustments or insurance payments
- Name of person who received service or supply

Section 2: (Please place each expense on a separate line)

a. Expense Code	b. Dates of Service		c. Provider of Service	d. Insurance Payments	e. Amount Requested	f. Total Charges	g. Person Who Received Service	h. Relationship	i. Birthdate
	From	To							

I authorize the expenses listed above to be reimbursed through my Health Care Flexible Spending Account. I certify that, to the best of my knowledge, the health care expenses I am submitting would have been tax deductible expenses. I further certify that these expenses are not reimbursable under any other plan, including a plan of another employer that covers me, my spouse or another member of my family.

EMPLOYEE SIGNATURE _____ **DATE** _____