



FLEXIBLE SPENDING CLAIM FORM

Medical Reimbursement Account (MRA)

EMPLOYER _____

About the Employee: For ALL claims - this area must be filled out completely

EMPLOYEE	Employee's Name (Please Print Full Name)			Member's ID Number		
	Last	First	Middle Initial	Employee's Date of Birth		
	Address			Month / Day / Year		
	City		State	Zip	Daytime Telephone Number	
	<i>New address? Contact your employer's personnel office to make the appropriate changes</i>					
<p>Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud, submits an application for coverage or files a claim containing a false, misleading or deceptive statement is guilty of insurance fraud. I certify that I have incurred the expenses for which reimbursement is claimed for the Flexible Spending Account and I further declare that I have not and will not claim credit for these expenses on my individual income tax return.</p>						
Signature (Required)				Date		

Items Submitted for Reimbursement from your Medical Reimbursement Account(MRA)

REIMBURSEMENT	<p>Attach Itemized receipts or an explanation of benefits from your Insurance Company for reimbursement of medical, dental, vision or prescription expenses.</p> <p>INFORMATION REQUIRED ON ITEMIZED RECEIPTS INCLUDE:</p> <p>(1) Patient Name (2) Services performed. (3) Date services were incurred. <i>(IRS guidelines prohibit pre-payment for future dates of service such as orthodontics.)</i></p> <p style="background-color: #f2f2f2; padding: 2px;">The following documentation is NOT sufficient for medical reimbursement: Check stubs, cancelled checks or cash register receipts; balance forward bills (IRS guidelines require date of service.)</p>			
		Date of Service	Provider	Amount
	<p>On your itemized receipts, please circle all charges you would like reimbursed and list the charges here.</p> <p>To keep small receipts from getting separated during processing, we suggest you tape them to a single sheet of paper. Thank You!</p>			
	Total amount submitted for reimbursement:			

Mail completed form and receipts for reimbursement to:

Meritain Health
19800 Detroit Road • Cleveland, Ohio 44116-1816

If you require assistance in presenting this claim, call your Service Delivery Team at the number listed on your healthcare I.D. card.