



12429

# FSADirect REQUEST FOR MEDICAL REIMBURSEMENT

PLEASE PRINT CLEARLY. USE ALL CAPITAL LETTERS



## GENERAL INFORMATION

Group: Davidson College

Plan ID: 100653513

Soc. Sec #  If this is a new address, check here



Name  Last  First

Address

City  State  ZIP  -

Phone (  ) -  -  E-Mail

- You must attach an itemized bill or explanation of benefits (EOB) form for healthcare expenses. Do not attach checks or credit card slips as you may be required to provide additional documentation.
- Expenses that **CAN NOT** be reimbursed include cosmetic expenses, insurance premiums, and general wellness expenses.
- Fax the claim to 1-800-726-9982 or 704-335-0818 in the Charlotte area.
- Or mail to: Claims Processing • P.O. Box 31397 • Charlotte, NC 28231-1397

Claims Submission Deadline:

**February 28**

You have until the above day after the end of the plan year to submit claims for the previous plan year.

## REIMBURSEMENT REQUEST DETAIL

Please complete one section for each included receipt at total at the bottom. Use additional forms as needed.

Date Of Service (not payment date)  /  /  Service Code (see key below)  Amount Requested for Reimbursement

Patient Name  Name of Provider

Date Of Service (not payment date)  /  /  Service Code (see key below)  Amount Requested for Reimbursement

Patient Name  Name of Provider

Date Of Service (not payment date)  /  /  Service Code (see key below)  Amount Requested for Reimbursement

Patient Name  Name of Provider

Date Of Service (not payment date)  /  /  Service Code (see key below)  Amount Requested for Reimbursement

Patient Name  Name of Provider

01 - Medical      03 - Vision      05 - Mileage      07 - Other  
 02 - Dental      04 - Prescription      06 - Orthodontia      08 - Over The Counter

Amount Requested For This Page

## REIMBURSEMENT AUTHORIZATION

I certify that I have not previously requested reimbursement for the above expenses under this or any other plan and I am not able to receive additional insurance benefits or reimbursements from any other source for these expenses. I certify that these expenses are eligible for reimbursement in accordance with the Flexible Spending Account SPD provided by my employer. I further certify that these expenses are for eligible dependents as defined under Internal Revenue Code Section 152.

Participant Signature (void if not signed)  Date Signed