



**Washington County Commissioners**  
**FLEXIBLE SPENDING ACCOUNT**  
**REIMBURSEMENT REQUEST FORM**

NAME: \_\_\_\_\_ SOCIAL SECURITY : \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PLEASE CHECK IF ADDRESS HAS CHANGED

**NOTE:** Please read the instructions on the back of this page prior to submitting for reimbursement and remember to **STAPLE** all necessary receipts to this form.

**HEALTH CARE EXPENSE REIMBURSEMENT REQUEST: (PLEASE LIST EACH EXPENSE SEPARATELY)**

DATE EXPENSE INCURRED	DESCRIPTION OF EXPENSE	AMOUNT	CLAIM CODE * (see below)
		\$	
		\$	
		\$	
		\$	
		\$	
	<b>TOTAL:</b>	\$	

\*C =CO-PAY; D =DENTAL; M=MEDICAL; O = OVER-THE-COUNTER MEDICINE; R = RX; V = VISION

**DEPENDENT CARE EXPENSE REIMBURSEMENT REQUEST:**

DATES OF DEPENDENT CARE	TAX ID # / SOC. #	PROVIDER	AMOUNT	LEVEL ** (see below)
			\$	
			\$	
			\$	
			\$	
			\$	
	<b>TOTAL:</b>		\$	

( Overnight Camp, Kindergarten, First Grade and above are not eligible expenses through the Dependent Care Account. )

\*\* DC = Daycare, PS = Preschool, CP = Camp, OT = Other (please explain)

\*Signature of Dependent Care Provider: \_\_\_\_\_ \* Signature or Receipt from Provider is required

I hereby certify that the information contained on this form is, to the best of my knowledge, true and correct, and the expenses are eligible for reimbursement and have not been paid through insurance or reimbursed from any other source. I also certify that the expenses are for myself or an eligible dependent, under the definition of IRS Code Section 152. I understand I am responsible for providing proof to support a reimbursed expense and that any expense later discovered to be not eligible for reimbursement will be taxable to me.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

## **STEPS TO RECEIVE REIMBURSEMENT:**

1. Only submit expenses incurred (date of service) in the current Plan Year.
2. With all requests for reimbursement you must provide:
  - date expense incurred (actual date of service) – NOT date of payment
  - description of expense
  - amount submitted for reimbursement
  
  - an Explanation of Benefits (EOB) OR receipt from the provider showing date of service,  
procedure performed and amount you are responsible to pay
  
  - a tax id/social security #, provider name and level for all day care expenses
  
  - a receipt from the day care provider showing proof of amount paid OR the day care provider's signature on the front of this form
3. The reimbursement form must be completed, signed and dated or it will be returned for the missing information.
4. All expenses must be listed on the front of the claim form or listed on an attached spreadsheet. Any form that does not have a listing of the claims that you are requesting reimbursement for will be returned.
5. Do not staple more than one claim form together; complete as many claim forms as necessary but total each form and attach the corresponding receipts to each form.
6. When filing for two different plan years (at the end of your plan year during the grace period), use two separate claim forms; one for each plan year.
7. When submitting claims by fax, please do not mail a copy of same claim.
8. You cannot submit a claim for a service that has not yet been rendered.

\*\*\*No reimbursement will be made without all necessary information.\*\*\*

Reimbursement requests may be sent directly to CBIZ Benefits & Insurance Services either by fax OR by mail to the following address:

CBIZ Benefits & Insurance Services of Pennsylvania  
Attn: Flex Department  
401 Plymouth Road Suite 200  
P.O. Box 1000  
Plymouth Meeting, PA 19462-1000  
PHONE – 610-862-2354  
FAX – 610-862-2501