Clear Form

Flex & HRA/MRA Reimbursement Claim Form

Fax Claims to: (855) 306-1098 Attn: TPA Claims Dept. or email to: claims@44n.com

Total Pages: _____

Company Name EMMET COUNTY ROAD COMMISSION		
Employee Name (Please Print or Type)	Social Security Number XXX-XX-	Daytime Phone
Address (only complete if new)		

To receive reimbursement for eligible expenses incurred during the plan year, mail, email or fax this completed and **signed** claim form along with IRS-required documentation of the expense from an independent third party (such as Insurance EOB, receipt or statement), which must include all of the following:

- Date of service/purchase
- Name of person receiving service
- Name of Provider of service
- Type of service/supply provided (name of OTC item must be printed directly on the receipt or submitted with product packaging with price tag on it)
- Amount charged for each service/supply or the amount not reimbursed by insurance

CANCELLED CHECKS DO NOT QUALIFY AS THIRD-PARTY DOCUMENTATION AND ARE NOT ACCEPTED BY THE IRS

Health Care Expense Reimbursement (HRA/MRA — Employer Funded)

☐ **Reimburse from Attached EOBs and / or Rx Receipts** (See SPD For Eligible Expenses)

☐ **Reimburse ineligible from Flex**

☐ Coordination with another Insurance Carrier (Please submit EOB from other carrier i.e. Medicare, Priority, BCBS, Aetna)

Date of Service	Physician or Provider Name	Type of Service/Supply	Amount Paid	Amount to be Reimbursed
		Total to Be Reimbursed	**$**	0.00

Flexible Health Care Expense Reimbursement (FSA / Employee Funded)

Date of Service	Physician or Provider Name	Type of Service/Supply	Amount Paid	Amt to be Reimbursed
		Total to Be Reimbursed	**$**	0.00

Flexible Dependent/Child Care Expense Reimbursement

Dates of Service	Name of Person(s) Receiving Service	Relationship to Employee	Age(s)	Amount
		Total to be Reimbursed	**$**	0.00

Name of Provider: _____ Provider's Taxpayer ID# _____

Address of Provider: _____

Is Provider related to participant? ☐ Yes ☐ No If Yes, please describe: _____

*Signature of Care Provider _____ Date: _____

**If you DO NOT have a receipt with complete information your claim will not be reimbursed unless your daycare provider has signed this form.*

I hereby certify that all the medical expenses on this reimbursement form have been incurred by me, my spouse and/or my eligible dependents during the plan year and qualify for reimbursement. I understand that medical expenses are deemed to have been "incurred" when the services giving rise to the claim are rendered, regardless of when I am formally billed, charged or pay for the service. I certify the expenses are medical expenses as defined in Section 213(d) of the Internal Revenue Code of 1986, and are not for cosmetics, cosmetic surgery, premiums on accident or health insurance or coverage for long-term care services. I certify that these expenses have not been or will not be reimbursed under this or any other benefit plan. I also understand that any reimbursed expenses cannot be used to claim a deduction or credit on my personal income tax return. I agree to file IRS Form 2441 with my tax return and provide any required taxpayer identification numbers for reimbursements from my DCAP account. This is not a guarantee that the payment is tax-free if the requested items do not meet IRS rules.

Employee Signature: _____ **Date:** _____