Flexible Spending Account Reimbursement Request Form

Instructions: : Please print or type and complete all items under Personal Information. In order to receive reimbursement, you must submit an Explanation of Benefits (EOB) (if applicable) from your insurance carrier or an itemized statement that includes the provider, patient name, date(s) of service, description of service, insurance responsibility (if applicable) and patient responsibility/payment for each health care claim. For Dependent Care reimbursement, please use the DCA Claim Form.

Personal Information

Employer's Name	Email Address
Employee's Name	Date of Request
Employee's Last 4 Digits of Social Security Number	Daytime Phone Number

Health Care Expenses

Patient Name	Relationship	Age	Date of Service	Type of Service	Requested Amount

(If more space is needed, please copy this claim form or attach additional pages)

Total: $_____

I, the undersigned, hereby certify that the above listed expenses have not been previously reimbursed from my Flexible Spending Account, nor are reimbursable from any other source. I hereby authorize Alliance Insurance Group, LLC to obtain necessary information from all physicians, hospitals, employers and all other agents in order to adjudicate the claim for reimbursement under the Benefit Plan established by my employer. I understand that the amount requested may not equal the amount reimbursed. The reimbursable amount is based on the available balance at the time of the claim. I also understand that dates of service prior to the plan start date are not eligible for reimbursement under the current plan year. Should receipts be requested or more information needed, I will provide the requested documentation to Alliance Insurance Group, LLC in order to process the claim in a timely manner.

Employee Signature:_____ Date: _____

Alliance Insurance Group
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