MedCost Benefit Services
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1-877-275-2718 www.MedCost.com

Flex Plan Manual Claim Form

Flexible Spending Accounts For Health or Dependent Care

Account Holder Information

Last Name	First Name	Group Number
Address (Check if new address) ☐		Member ID
Email Address		Contact Number

Health Care Claims For Reimbursement

Note: Expenses must have been incurred during the plan year and not reimbursed from any other source or claimed on your personal tax return.
For all expenses attach a copy of itemized bills or the explanation of benefits from your insurance carrier that clearly state:
1) Name of person receiving the service 2) Nature of service or supply 3) Name and address of provider of service
4) Amount charged 5) Date service was rendered 6) Please provide prescriptions for over-the-counter medications

1) ☐ Rx ☐ Over the Counter ☐ Dental ☐ Other: ☐ Office Visit ☐ Hospital ☐ Vision
___ ___ / ___ ___ / ___ ___ Beginning Service Date (MM/DD/YY) $_____ Amount
☐ Self ☐ Child ☐ Spouse

2) ☐ Rx ☐ Over the Counter ☐ Dental ☐ Other: ☐ Office Visit ☐ Hospital ☐ Vision
___ ___ / ___ ___ / ___ ___ Beginning Service Date (MM/DD/YY) $_____ Amount
☐ Self ☐ Child ☐ Spouse

3) ☐ Rx ☐ Over the Counter ☐ Dental ☐ Other: ☐ Office Visit ☐ Hospital ☐ Vision
___ ___ / ___ ___ / ___ ___ Beginning Service Date (MM/DD/YY) $_____ Amount
☐ Self ☐ Child ☐ Spouse

4) ☐ Rx ☐ Over the Counter ☐ Dental ☐ Other: ☐ Office Visit ☐ Hospital ☐ Vision
___ ___ / ___ ___ / ___ ___ Beginning Service Date (MM/DD/YY) $_____ Amount
☐ Self ☐ Child ☐ Spouse

Total Health Care Expenses Being Claimed $

Dependent Care Reimbursement

Dependent care expenses are eligible for children through age 12 or for dependent, disabled adults. The IRS requires that the name, address, and tax id number of your dependent care provider be on file with the administrator.

Provider Name	Provider SS # / TIN		
Street Address	City	St	Zip
Provider Signature		Date	

Dependent Name	___ ___/___ ___/___ ___ Service Date (MM/DD/YY) to ___ ___/___ ___/___ ___ Service Date (MM/DD/YY)	$
Dependent Name	___ ___/___ ___/___ ___ Service Date (MM/DD/YY) to ___ ___/___ ___/___ ___ Service Date (MM/DD/YY)	$
Dependent Name	___ ___/___ ___/___ ___ Service Date (MM/DD/YY) to ___ ___/___ ___/___ ___ Service Date (MM/DD/YY)	$

Total Dependent Care Expenses Being Claimed $

Important! To prevent delays, please attach paid receipts or copies of bills (not canceled checks) to verify expenses.

Certification

These expenses were incurred while I have been a covered participant, and to the best of my knowledge are reimbursable by the plan. I have not and will not be reimbursed for these amounts from any other source.

Signature	**Date**