MEDICAL FLEX REIMBURSEMENT FORM

EMPLOYEE NAME:____________________________EMPLOYEE EMAIL ADDRESS:__________________

EMPLOYEE ADDRESS (enter address information only if you had a recent change)

Street:______________________________ City:______________________________Zip Code:________

THE FOLLOWING REIMBURSEMENT REQUEST RULES APPLY:

1. Attach Explanation of Benefits to establish amounts not covered under the medical/dental plan.
2. Receipts (photocopies are acceptable) must include the following: name of provider, type of service/purchase, charge for each service/supply. Receipts must be 8.5 x 11 format.
3. Canceled checks are not acceptable
4. Expenses must be incurred during the Plan Year. Date of payment to provider is not relevant.
5. To help ensure that you will not have a delay in your reimbursement please be sure that all supporting documents are attached to the reimbursement form.
6. **Mail receipts to: AGA♦ 7605 Westfield Dr., FWI. 46825♦Email: flex@aga-tpa.com♦fax: (260)489-0365**

MEDICAL EXPENSE CLAIMS

CLAIMANT NAME	NAME OF PROVIDER	DATE INCURRED	SERVICES: (medical, dental, etc)	NET AMOUNT
TOTAL:				

I certify that all items required to be reimbursed with the City of Fort Wayne's Flexible Spending Account Program will not be covered by any other plan or program of any employer or other person. The City of Fort Wayne does not accept responsibility for direct payment to any individuals other than the employee.

Employee Signature:____