FLEXIBLE SPENDING ACCOUNT

REIMBURSEMENT REQUEST

|  |  |  |
| --- | --- | --- |
| **SKILLSOURCE** | | Employee Social Security # |
| Employee Name | | Employee Daytime Phone Number |
| Employee Address | | |
| City | State | Zip |

**Health Care Expenses**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name | Relationship to Employee | Provider Name  (doctor/pharmacy name) | Date of Service | Total Charge | Amount Paid By Other Sources | Amount To Be  Reimbursed |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  | | | | | |  |

\*Attach receipts

I hereby request payment from my flexible spending account for the expenses listed above. I certify that I have not been reimbursed for these expenses from any other health plan. I understand that any expenses reimbursed may not be used to claim any federal income tax deduction or credit. I hereby authorize a deduction from my flexible spending account.

Signature of Employee: Date