

**M-Flex  
Flexible  
Spending**

Submit to:  
Network Claims Administration  
PO Box 828  
Colorado Springs, CO 80901-0828  
719/365-5025



**Reimbursement Request Claim Form**

**Group 50102**

|   |       |   |  |
|---|-------|---|--|
| Memorial Health System Employee ID Number |       | Employee's phone number<br>Work: _____<br>Home: _____ |  |
| Employee's Last Name                      | First | MI  | Employee's birthdate<br><input type="checkbox"/> Male<br><input type="checkbox"/> Female |
| Address Street                            |       | <input type="checkbox"/> Check here if new address    |  |
| City                                      | State | Zip   | If name change, give former name   |

**AMOUNT**

*Dependent Care reimbursement submission* \$ \_\_\_\_\_

Day Care Claim Information (Attach signed receipt from provider):

Provider of Day Care Service: \_\_\_\_\_

Tax ID# of Provider: \_\_\_\_\_

*Medical claim expense out-of-pocket reimbursement submission* \$ \_\_\_\_\_

You must attach to this form the supporting receipts, statements and/or insurance Explanation of Benefits (EOB) for each expense claims. Documentation must be a copy of the billing, itemizing the expense and including dates of service, a receipt that indicates the performance and payment of this service, and a copy of an EOB from your medical/dental carrier(s).

***Incomplete or incorrect reimbursement request forms will not be processed.***

I hereby certify that all items requested for reimbursement ARE FOR THE EXPENSES THAT HAVE BEEN INCURRED and comply with the Memorial Health System Flexible Spending Benefits Plan. Such items have not and will not be covered by any other plan or program of any employer or other person. I further certify that such items WILL NOT be deducted or taken as tax credits on my personal federal and state income tax return for any year and that the expenses were purchased for services for my legal dependents. Memorial Health System does not accept any responsibility for direct payment to any individuals other than the employee.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_