ADMINISTRATION PROVIDED BY:
Diversified Administration Corporation
PO Box 299, Marlborough, CT 06447
860-295-0238, toll free 888-322-2524

Section 125 -Medical Reimbursement
Flexible Spending Reimbursement Request Form

Rules and Instructions for completing Medical Reimbursement Form

- I understand that reimbursements cannot exceed the annual amount elected in this account, also I certify that I have paid the above expenses for which reimbursement is claimed for myself or my eligible dependents which are legitimate expenses incurred on the dates noted and are not payable by insurance coverage, nor will I seek reimbursement under any other plan.
- I understand that the date the service was incurred is the date used for claim processing, not the date the provider was paid.
- I understand that the IRS "Use It Or Lose It" rule applies and that any unused balances remaining in my account at the end of the Plan Year will be lost (forfeited) and no longer available to me. Reimbursement requests must be made within the 59 day run off for the Plan Year. (February 28th).
- I understand that I am responsible for income tax impacts and compliance with the Internal Revenue Service.
- I understand that I am responsible for any occurrence of inappropriate use or disclosure of my information due to my selected method of transmitting this request (e.g. fax, e-mail or any other method).
- I authorize the Plan and its service provider (DAC), their employees, and subcontractors to use and/or disclose the information provided below; as they deem necessary to manage the Plan (including but not limited to disclosures to my employer for Plan administrative purposes, such as the evaluation of eligibility for reimbursement under the Plan) and to detect fraud or misrepresentation.
- I understand that the IRS requires adequate claim substantiation from a third party and that all requests must be remitted with the proper substantiation to include an itemized invoice or statement from the medical provider or pharmacy clearly stating:
    - the nature of the service
    - specific purpose for the service or expense
    - the date the service was incurred
    - the date the expense was paid
    - to whom the services were provided (patient)
    - If other coverage is involved; copies of the Explanation of Benefit (EOB) statement from your health insurance, or
      A statement, in writing, from myself (or my Authorized Representative) that the expense has not been reimbursed under any other health coverage or plan, and that you will not seek reimbursement under any other health plan or insurance policy.

Please retain your original documentation/substantiation
Submit your request to: **Diversified Administration Corp., PO Box 299, Marlborough, CT 06447 or Fax to: 860-295-6579**
For inquiries regarding a processed request, contact Diversified Administration Corp. Flex Dept.: 860-295-0238 or toll free 888-322-2524 or
E-mail: eebenereim@diversifiedgb.com

Employer Information

Group Name: **Research Foundation For Mental Hygiene, Inc.** **Group Number: DAC274G**

Employee Information

Last Name: _____First Name:_____IdentificationNumber:_____

Address:_____City:_____ ST: _____Zip Code:_____ Ph. No. _____

If your company provides Auto-Rollover from Claims processing to your Flex Acct., you need not submit a manual claim. You or your provider remit the Claim to your Health Insurance Plan, once completed any eligible expense will automatically be paid to you from your Flex Account.

****Checks will not be issued for amts. less than $10.00. Requests for under $10.00 will be applied to future payments or at end of the Plan Year.****

Expense Type Codes: **M** = Fees to Offices & Labs **A**= Dental Care **V** = Vision **R** = Prescription Drugs **O** = Other & Over-the-counter+

Services Provided By	Patient Name(s)	Expense Code	Date Incurred	Total Expense	Reimbursement Requested
				$	$
				$	$
				$	$
				$	$
				Total Reimbursement Requested:	$

*** Participant's Signature:_____ _____ _____ _____** **Date: _____**

**** IMPORTANT: Request cannot be processed without the participant's signature.***