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

Section 125 -Medical Reimbursement
Flexible Spending Reimbursement Request Form

Instructions for completing Medical Reimbursement Form

Complete the information below for Medical Care Expenses incurred by you, your Spouse, or your other eligible Dependents. You must provide insurance Explanation of Benefits statements (**EOBs**), itemized hospital or doctor's bills, pharmacy receipts, or other evidence from independent third parties that the Expenses were incurred (no cancelled checks). Be sure to provide all information requested on this Form. Please date and sign the Form, then send it along with your supporting documentation to: **Diversified Group, PO Box 299, Marlborough, CT 06447; or Fax to: (860) 295-6579 or (860) 295-1296.**

For inquiries concerning a reimbursement request, contact:
Diversified Administration Corporation's Flex Dept at: ***(860) 295-0238*** *or toll free:* ***888-322-2524;***
or by E-mail: eebenereim@diversifiedgb.com.

Employer Information

Group Name: **Research Foundation for Mental Hygiene** **Group Number:** **DAC274G** **Plan Year:** **2021**

Employee Information

Last Name: _____First Name:_____IdentificationNumber:_____

Address: _____ City:_____ ST: ____Zip Code:_____ Phone 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:		$

I authorize the above expenses to be reimbursed from my Health FSA Account. To the best of my knowledge, my statements in this Form are true and complete. I certify all of the following:

- Either I, my Spouse or Dependent Child received the service(s) described above on the dates indicated.
- The expenses qualify as valid Medical Care Expenses under Code § 213(d). These expenses are for medical care excluding cosmetic purposes, are not incurred for general health purposes, and do not constitute toiletries.
- These expenses have not been previously reimbursed under the Health FSA or any other plan, and I will not seek reimbursement for them under my Employer's health plan or any other health plan.

In addition, I understand that expenses for which I am reimbursed may not be used to claim federal income tax deduction or credit. I also understand that I may be asked to provide further details about some expenses.

_____ _____

Employee's Signature *Date*