



Your Solution to Health Benefits

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](mailto:eebenereim@diversifiedgb.com).*

**Employer Information**

**Group Name: Research Foundation for Mental Hygiene      Group Number: DAC274G      Plan Year: 2022**

**Employee Information**

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **Identification Number:** \_\_\_\_\_  
**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
				\$	\$
				\$	\$
				\$	\$
				\$	\$
				\$	\$
<b>Total Reimbursement Requested:</b>				\$	\$

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