



P.O. Box 348  
 One Dodge Street  
 North Greenbush, NY 12198  
 (518) 283-8500  
 Fax (518) 283-2393  
 800-698-4753  
 claims@benetech.cc

# Flexible Spending Account

## MEDICAL EXPENSE RECOVERY FORM

EMPLOYER (COMPANY) NAME AND ADDRESS: \_\_\_\_\_

EMPLOYEE NAME: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
(street) (city) (state) (zip)

If new, check here

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

PATIENT RELATIONSHIP TO EMPLOYEE: \_\_\_\_\_ CHILD \_\_\_\_\_ SPOUSE \_\_\_\_\_ OTHER: \_\_\_\_\_  
(please specify)

When submitting this form you must complete the information requested below and attach an ITEMIZED RECEIPT, CANCELLED CHECK OR OTHER PROOF OF PAYMENT.

DATES OF SERVICE	NAME OF PROVIDER	AMOUNT REQUESTED FOR REIMBURSEMENT
------------------	------------------	------------------------------------


By signing and submitting this form you acknowledge that all requirements of Section 213 of the IRS code, as well as the plan document of your employer, have been satisfied.

I hereby certify that the above statements are complete and accurate to the best of my knowledge. I also agree to reimburse my employer and/or the administrator to the extent of an overpayment which is in excess of the amounts payable under the plan.

**ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR ADMINISTRATOR FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.**

EMPLOYEE SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_