EBMS
*Employee Benefit Management Services, Inc.*
P.O. Box 21367 • Billings, MT 59104-1367
Toll Free 1-866-857-8182 • (406) 869-6526
Toll Free Fax 1-877-236-9868 • Email: flex@ebms.com

# REQUEST FOR FLEX REIMBURSEMENT

**Please complete applicable spaces on this form, attach appropriate bills, and forward to EBMS. (Cancelled checks or balance due statements are not acceptable bills.)**

**❑ Check if address has changed**

Employer _____ Group Number _____

Employee Name _____ Member ID # _____
Last First Middle

Home Address _____
Number/Street City State Zip

**UNREIMBURSED MEDICAL EXPENSE CLAIMS**

| Date Incurred | Name of Service Provider | Expense Description | Person for Whom Incurred | Net Amount |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | TOTAL MEDICAL CARE EXPENSE CLAIM | | |

**DEPENDENT CARE EXPENSE CLAIMS**

| Name of Dependent(s) | Period Covered | | Name, Address and Taxpayer Identification Number of Provider of Service | Amount Incurred |
|---|---|---|---|---|
| | From | To | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | TOTAL DEPENDENT CARE EXPENSE CLAIM | |

To the best of my knowledge, the statements made within this Request for Reimbursement are complete and true. I am claiming reimbursement for eligible expenses incurred during the applicable plan year by eligible plan participants. **The medical expense requested has not been reimbursed or is not reimbursable by any other health coverage and will not be claimed as an income tax deduction.** I authorize my Flexible Spending Account to be reduced by the amount requested.

Employee's Signature _____ Date _____

For Dependent Care Expenses, the following must be completed by the Daycare Provider:
To the best of my knowledge, I certify that the information above regarding dependent care expenses is complete and true.

Dependent Care Provider Signature _____ Date _____