

Pre Tax Plan Reimbursement Request Form

Advanced Benefit Strategies

Your Flexible Benefits Specialists

www.abs125.com

Fax claims to: 860-673-2207
 Mail claims to: Advanced Benefit Strategies
 30 Mill Street
 Unionville, CT 06085
 Call: 860-675-2261 • Toll Free: 877-732-8125

Employee Name:			
Company/Employer Name:			
Social Security Number <i>(or Employee ID, If Applicable):</i>			
Email:	New Email:	Yes	No
Phone:			

All documentation must be attached and include:

- Name and address of provider
- Date of service
- Services rendered on that date
- The portion of charges you are responsible for

Credit card receipts/statements, Cancelled checks, & Balance forward statements aren't considered acceptable forms of documentation by the IRS.

HEALTHCARE		
Date:	Type (RX, co-pay, contact solution, etc.)	Cost:
TOTAL:		HEALTHCARE

DEPENDENT CARE			
Date:	Dependent(s) Name:	AGE:	Cost:
TOTAL:			DEPENDENT CARE

I certify that the above reimbursement submissions are for eligible expenses incurred for my spouse, eligible dependent or myself. I will not receive payment from any other source for any of these expenses. If I am enrolled in an HSA I am submitting for only vision and or dental claims or medical expenses after IRS minimum deductible is met.

SIGNATURE: _____ **DATE:** _____

OVER THE COUNTER MEDICATIONS MAY BE SUBMITTED FOR REIMBURSEMENT. VITAMINS & SUPPLEMENTS, TEETH WHITENING PRODUCTS AND WARRANTIES ARE SAMPLES OF EXPENSES THAT ARE NOT ALLOWED AS THEY ARE CONSIDERED NOT MEDICALLY NECESSARY BY THE IRS.

View our website, www.abs125.com for complete description of eligible/ineligible items or shop at www.fsastore.com for your medical needs.