Print Form

FLEXIBLE SPENDING ACCOUNT
REIMBURSEMENT FORM
HEALTH CARE ACCOUNT

PERSONAL INFORMATION:

Employer: Select Plan Year: SS #: .

Employee Name: Phone No: .

Home Address: .

AUTHORIZATION:

I certify that the expenses for reimbursement requested from my Health Care Reimbursement Account (HCRA) were incurred by me (and/or my spouse and/or persons who meets the definition of eligible dependents), were not reimbursed by another plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my HCRA. If the reimbursement is request for prescriptions, I certify that such drugs are not prescribed for cosmetic purposes (ex. hair growth, weight loss, etc.) I (or we) understand that expenses reimbursed through the HCRA can not be used as deductions or credits when filing my (our) income tax return**.**

EMPLOYEE SIGNATURE: DATE: .

HEALTH INFORMATION

Name of Patient	Type of Service	Dates of Service	Reimbursement Requested
1.			
2.			
3.			
4.			
5.			
6.			
7.			

TOTAL

Please review this form carefully. Forms improperly completed will be returned and may result in a delay in your reimbursement. Please submit a copy of the bill(s) and an explanation of benefits from your insurance company. **Canceled checks will not be accepted**.

Mail completed signed forms to:

Oneida BOCES
Flex Benefit Program
P.O. Box 70 Middle Settlement Road
New Hartford, NY 13413