



Flexible Spending Account (FSA) Reimbursement Request

Employee Information

First Name _____ Middle Initial _____ Last Name _____
 Address _____ City _____ State _____ ZIP _____
 Phone _____ Last four of SSN _____ Employer _____
 Email (required) _____

Expenses

Complete the following and **attach an Explanation of Benefits and/or detailed invoice noting the date of service, provider and amount of expense.** Please log in to your account to add banking information for direct deposit reimbursement if you have not yet done so.

NOTE: Balance forward statements, cancelled checks and credit card receipts are not sufficient documentation for reimbursement.

Unreimbursed Medical Expenses			
Patient	Date of Service	Provider Name and Address	Amount

Dependent Daycare Expenses			
Dependent	Date of Service	Provider Name and Address	Amount

Daycare Provider Signature _____ Tax ID _____ Date _____

Limited Purpose Expenses			
Patient	Date of Service	Provider Name and Address	Amount

I request reimbursement for the expenses listed above. I confirm that the services were received by the individuals listed on the dates described. I have attached the appropriate Explanation of Benefits and/or receipts. I accept full responsibility for the accuracy and sufficiency of these documents. I certify that these expenses were incurred while I was covered under my employer's Flexible Spending Account. I will not seek reimbursement from another health insurance plan. I understand that the Internal Revenue Code forbids me from claiming the above expenses as credits or deductions on my personal tax return.

After signing below, fax or mail the form to **INSURAPATH**.

Employee Signature _____ Date _____

Insurapath, Inc. 5300 S Broadband Lane Sioux Falls, SD 57108
 Phone: 605-322-4774 Fax: 605-504-9305 Email: Flex@Insurapath.com

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