Niagara Falls City School District (Actives)

M&T Insurance Agency, Inc.

MEDICAL AND DEPENDENT CARE EXPENSE ACCOUNT
REIMBURSEMENT REQUEST FORM

Name	SS#	**Submit claims to:** Flexible Benefits Card Support PO Box 540606 Waltham MA 02454 OR Fax: 1-877-767-8685 Ph:1-855-680-0897, press Option 2
Home Address	Address Change ☐Yes ☐ No	
City	State / Zip	
Phone: Work Home	e-mail:	

Complete the information below for expenses incurred by you, or any eligible dependents for which you request reimbursement. You must provide itemized receipts or other evidence illustrating that the expense was incurred. Be sure to provide all information requested on this form. If the form is incomplete your claim will not be processed and this form will be returned to you. Print or type the information requested, then sign and date the form.

HCRA
MEDICAL EXPENSES (Medical, Dental, Vision or HRA)

	Provider of Service (Doctor, dentist, pharmacy, etc.)	Person Receiving Service (Name and SSN)	Dates of Service (MO/DAY/YR)	Amount of Expense Claimed	Nature of Expense
1				$	
2				$	
3				$	
4				$	

DCRA
DEPENDENT CARE EXPENSES (if necessary, attached additional sheets)

	Provider of Service	Person Receiving Service (Name and SSN)	Age of Dependent	Dates of Service (MO/DAY/YR)	Amount of Expense Claimed	Provider Tax I.D. Number (Social Security Number if Individual)
1					$	
2					$	
3					$	

Dependent Care Provider's Signature (if individual)_____

I hereby request reimbursement from my applicable flexible spending account(s), pursuant to the plan and applicable law, for the expenses listed above. I hereby represent and certify that the above expenses have actually been incurred and that these expenses have not and will not be reimbursed any benefit plan and will not be claimed as an itemized income tax deduction.

Employee Signature_____Date_____

PLEASE SEE REVERSE SIDE FOR FILING INSTRUCTIONS

M&T Insurance Agency, Inc.

INSTRUCTIONS FOR COMPLETION OF FLEXIBLE SPENDING CLAIM FORMS

HCRA

HEALTH CARE EXPENSES (Medical, Dental, Vision)

- Complete claim form – all requested information must be provided or claim will be denied.
- Attach originals or copies of medical bills, insurance explanation of benefits, prescription drug receipts, cash register receipts, etc. The documentation must provide the following information or the claim will be denied:
    1. Name of provider of service (doctor, dentist, pharmacy, etc.)
    2. Name of person receiving service (self, spouse, dependent)
    3. Date of service
    4. Explanation of procedure
    5. Cost of procedure less any amounts paid by primary insurance provider

- Mail or fax claim and expense documentation to:

Flexible Benefits Card Support
PO Box 540606
Waltham MA 02454
OR
Fax- 1-877-767-8685

DCRA

DEPENDENT DAY CARE EXPENSES

- Complete claim form – all requested information must be provided or claims will be denied.
- Attach originals or copies of daycare invoices or payment receipts issued by daycare provider. The documentation must provide the following information or the claim will be denied:
    1. Name of daycare provider
    2. Tax ID number or social security number of provider
    3. Name of dependent receiving daycare service
    4. Dates of service
    5. Cost of service

- Mail or fax claim and expense documentation to:

Flexible Benefits Card Support
PO Box 540606
Waltham MA 02454
OR
Fax- 1-877-767-8685

Claims are processed daily.