P.O. Box 348
One Dodge Street
North Greenbush, NY 12198
(518) 283-8500
Fax (518) 283-2393
800-698-4753
claims@benetech.cc

# Flexible Spending Account

# MEDICAL EXPENSE RECOVERY FORM

EMPLOYER (COMPANY) NAME AND ADDRESS: ______________________________

______________________________

EMPLOYEE NAME: ______________________ SOCIAL SECURITY #: ______________________

ADDRESS: ______________________________
(street) (city) (state) (zip)

☐ If new, check here

______________________________

PATIENT NAME: ______________________ DATE OF BIRTH: ______________

PATIENT RELATIONSHIP TO EMPLOYEE: ________ CHILD ________ SPOUSE ________ SELF ________ OTHER: ______________ (please specify)

When submitting this form you must complete the information requested below and attach an ITEMIZED RECEIPT, CANCELLED CHECK OR OTHER PROOF OF PAYMENT.

| DATES OF SERVICE | NAME OF PROVIDER | AMOUNT REQUESTED FOR REIMBURSEMENT |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

By signing and submitting this form you acknowledge that all requirements of Section 213 of the IRS code, as well as the plan document of your employer, have been satisfied.

I hereby certify that the above statements are complete and accurate to the best of my knowledge. I also agree to reimburse my employer and/or the administrator to the extent of an overpayment which is in excess of the amounts payable under the plan.

**ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR ADMINISTRATOR FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.**

EMPLOYEE SIGNATURE: ______________________________ DATE ______________