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 (last 4 digits only) *(or Employee ID, If Applicable)*:
Email: **New Email:** **Yes or 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:
	HEALTHCARE TOTAL:	

TRANSIT		
Date:	Transit Provider:	Cost:
	TRANSIT TOTAL:	

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

PARKING		
Date:	Garage/Parking Facility:	Cost:
	PARKING TOTAL:	

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.*