Flexible Benefits Reimbursement Voucher

PO Box 670329, Houston, TX 77267-0326 • Telephone: (866) 853-3539 • Fax: (800) 298-7785

PARTICIPANT INFORMATION

ADDRESS CHANGE? ☐ Yes ☐ No

NAME _____

MAILING ADDRESS _____

_____

CITY _____ STATE _____ ZIP_____

EMPLOYER _____

SOCIAL SECURITY # _____

E-MAIL ADDRESS _____

TELEPHONE (_____) _____

COMPLETE ONLY FOR DEPENDENT CARE PROVIDER

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP_____

SS # _____

TAX ID # _____

_____

SIGNATURE OF PROVIDER

COMPLETE ONLY FOR ORTHODONTIA REIMBURSEMENT

NAME _____

AMOUNT DUE $_____ DATE _____

SERVICE PERFORMED _____

I certify that the dental procedure for the above patient

☐ HAS BEEN COMPLETED ☐ IS IN PROGRESS

_____

SIGNATURE OF DENTIST / ORTHODONTIST

BENEFIT TYPE (please check as appropriate)

☐ MEDICAL REIMBURSEMENT ☐ DEPENDENT CARE REIMBURSEMENT ☐ PREMIUM REIMBURSEMENT

DATE OF SERVICE	FAMILY MEMBER	DESCRIPTION OF EXPENSE	AMOUNT
		GRAND TOTAL ALL PAGES	$0.00

IMPORTANT NOTICE ***Effective January 1, 2011, all over-the-counter items eligible for reimbursement must be accompanied by a doctor's prescription and a reimbursement voucher.***

ADDITIONAL FORMS AVAILABLE AT: www.ffga.com and click on Participant Forms

I hereby affirm that, to the best of my knowledge, all expenses listed above are eligible for reimbursement under Section 105(h) or 129 of the IRS Code and in accordance with my contract with First Financial Administrators, Inc. I further certify that these expenses have not been, nor will not be, reimbursed under any other health plan coverage. If you need verification of the eligibility of an expense, please contact First Financial Administrators, Inc. at 1-866-853-3539.

☐ Please send me additional envelopes (additional voucher given with every reimbursement)

NOTE: If you have direct deposit, First Financial Administrators, Inc. will not pay bank charges for Insufficient funds. Please call your financial Institution to verify deposit before writing any checks on the amount

SIGNATURE _____

DATE _____

Mail or Fax Completed Form To: First Financial Administrators, Inc. • P.O. Box 670329, Houston, TX 77267-0329 • Fax Number: 1-800-298-7785

Reimbursement Itemization

Continued

DATE OF SERVICE	FAMILY MEMBER	DESCRIPTION OF EXPENSE	AMOUNT
		SUB-TOTAL THIS PAGE	$0.00

MEDICAL REIMBURSEMENT SUBMISSION GUIDELINES:

ACCEPTABLE DOCUMENTATION to accompany the reimbursement voucher:

1. Professional bill or receipt that includes:
   - » Provider of service
   - » Type of service rendered
   - » Original date of service
   - » Charges for the service
2. Insurance company Explanation of Benefits
3. Pharmacy statement that includes Rx number and name of the prescription

DAYCARE SUBMISSION GUIDELINES:

ACCEPTABLE DOCUMENTATION to accompany the reimbursement voucher:

1. Vouchers for Dependent Care signed by the Provider. Voucher must also be completed with the Provider's tax identification number or Social Security number and dates of service, Or...
2. Voucher with receipt from Provider, including Provider name, Provider signature, dates of service, amount for service, and tax identification/social security number.

I.R.S Regulations prevent us from reimbursing dependent care yearly contracts. Monthly submissions are required.

UNACCEPTABLE DOCUMENTATION

1. Cancelled checks / Credit card receipts
2. Bill or receipt that only shows a balance forward or previous balance
3. Cash register receipt

Note: *It is important to note that the date of service, not the date of payment, must fall within the dates of the plan year for which you are enrolled.*