



Employee Benefit Management Services, Inc.

P.O. Box 21367 Billings, MT 59104-1367

Toll Free 1-866-857-8182

Toll Free Fax 1-877-236-9868 or E-mail flex@ebms.com

Request for Flex Reimbursement

Please complete applicable spaces, sign this form, attach appropriate receipts and/or EOBs (Explanation of Benefits) and forward to EBMS. Please note that canceled checks, balance due or balance forward statements, and credit card receipts are not acceptable bills.

Employer _____ Group Number _____
 Employee Name (Last) _____ (First) _____ (M.I.) _____ Member I.D. _____
 Home Address _____
 Check if change of address
 Phone Number () - _____ E-mail Address _____

Unreimbursed Health Care Expense Claims

Date of Service	Name of Provider	Expense Description- OV=office visit, Copay	Patient Name	Amount
				\$
				\$
				\$
				\$
				\$
				\$
				\$
Total Health Care Amount Requested				\$

Dependent Care Expense Claims

Name and Age of Dependents	Dates of Service		Name & Tax I.D. Number of Daycare Provider	Amount
	From	To		
				\$
				\$
				\$
Total Daycare Expense Requested				\$

For Daycare Expenses, the following must be completed by the Daycare Provider if a Tax ID Number is not available

To the best of my knowledge and belief, I certify that the information above regarding daycare expenses is complete and true.

Daycare Provider's Signature _____ Date _____

To the best of my knowledge and belief, my statements in the Request for Flex Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. **The medical health expense has not been reimbursed or is not reimbursable under any other health plan coverage and will not be claimed as an income tax deduction.** I authorize my Flexible Spending Account be reduced by the amount requested above.

Employee Signature _____ Date _____