Request for Medical FSA Reimbursement - Claim Form

☐ Please check here if new **mailing** address ☐ Please check here if new **email** address

Employer Name: Southeast Missouri State University

Employee Last Name: _____ **First Name:** _____

Address: _____

SSN: _____ **Contact Phone Number:** _____

Email Address: _____

Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this claim.
All information below must be completed.

Summit Card Purchase?	Service Date (mm/dd/yyyy)	Patient Name & Relationship	Provider Name	Description of Service	Amount
☐ Yes ☐ No					$
☐ Yes ☐ No					$
☐ Yes ☐ No					$
☐ Yes ☐ No					$
☐ Yes ☐ No					$
☐ Yes ☐ No					$
				Total	$

Employee's Certification for Disbursement

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/ or eligible dependents), were not reimbursed by any other plan, and to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return. I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee's Signature: _____ **Date:** _____

Submit completed form to:

email: claims@abadmin.com
fax: 405-775-5992
mail: 3817 NW Expressway, Suite 810 Oklahoma City, OK 73112

ASSURED BENEFITS ADMINISTRATORS