Please do not staple or tape your documents

Reimbursement Form for Flexible Spending Account "FSA"

*Note: You will need this form when submitting for reimbursement, please make copies
This form can also be downloaded at **www.healthplan.org**

Last:	First:	Middle:
Telephone #:	Your Employer:	
Vested Health Member ID #:	Email:	

Step 1. Complete the reimbursement form for eligible expenses incurred during your FSA plan year. When appropriate, health care expenses should be processed by your insurance company first. An expense is incurred when the service is provided, not when you are billed or pay for the service. Appropriate documentation must be included to process your reimbursement.

Health Care Expenses

Date of Service	Type of Service	Provider of Service	Reimbursement Amount
		TOTAL REIMBURSEMENT REQUESTED	

Dependent Care Expenses

Date of Service	Provider of Service	Tax ID or SSN	Reimbursement Amount
		TOTAL REIMBURSEMENT REQUESTED	

You may submit one reimbursement form for multiple service dates. For Dependent Care we will reimburse up to the amount you have deposited in your account to date, minus any previous reimbursements.

To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for myself and/or my legal dependent(s). I certify that these expenses have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction.

Your Signature _____Date_____
(Required to process)

Step 2. **"Please keep your original documentation"**
Submit this entire form and **copies** of your receipts, EOBs or other documentation to:

Mail: **The Health Plan-Account Processing**
PO Box 953, Charleston WV 25323-953
Fax: **1.866.347.3643**
Email: **customersolutions@healthplan.org**

Change of Address

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Phone: 304.347.3640/Toll Free: 866.347.3640