DeHEY McANDREW - Flexible Spending Account Claim Form

Employer Information: Name _____ Employer Address _____ Employer City, State _____ Employer Zip _____

Employee Name: _____ Social Security Number _____-_____-_____
(Last First Middle)

Address: Street _____ City _____ State _____ Zip _____

Is this Claim for: [ ] Medical Spending [ ] Dependent Care Spending

If this is Medical Spending:
Are you covered by another health plan? [ ] Yes [ ] No
If you are covered by your other plan, is it an HMO? [ ] Yes [ ] No
Does your other Plan include Dental, Drug or Vision coverage? [ ] Yes [ ] No

Medical Spending Claim:

Name of Patient: (Last First Middle)	Relationship to Employee	Amount Charged by Provider	Amount of Any Insurance Payment/ Reimbursement	Date of Service	Type of Service: (Exam, Rx drug, Orthodontia, Eye Glasses, etc.)	Name of Provider: (Hospital, Physician, Dentist, Pharmacy, Lab, etc.)
				___/___/___		
				___/___/___		
				___/___/___		
				___/___/___		

Dependent Care Spending Claim:

Name of Patient: (Last First Middle)	Relationship to Employee	Amount Charged by Provider	Date of Service	Nature of Service: (Daycare Center, Camp, household help)	Name of Provider:	Tax Identification Or Social Security Number
			___/___/___			
			___/___/___			
			___/___/___			

Complete This Section Only If You are Requesting Equal Monthly Payments to be Made Directly to a Provider.
I hereby authorize DeHEY McANDREW to pay provider cited in this Section. I attest these services are ongoing and qualified.
Provider Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Monthly Amount: $ _____

Claims Procedure:

1. Please complete this form and attach an itemized bill, Explanation of Benefits or receipt which you should obtain from your Provider.
2. Reimbursements are made on the 1st and 15th of each month. Some claims may be delayed due to coordination of benefits requirements.

I verify that the information that I have provided on this claim is accurate and that the expenses applied for herein are not a covered benefit on any existing Plan or reimbursable through any other Plan. **Please mail to:** Claims Department, DeHEY McANDREW - PO Box 447 - Scranton, PA. 18501 (570) 346-9960.

Signed: _____ Dated: _____/_____/_____

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