CORESOURCE
A Trustmark Company

CITY OF BOWLING GREEN #172
FLEXIBLE SPENDING ACCOUNT REQUEST FOR REIMBURSEMENT

Employee: ____ SSN: ________________________________

Address:____ Day Phone: ___________________________

____ ☐ **Indicate if new address**

Health Care Expenses
For any claims covered under your Plan, remember to submit these first for payment. Then attach a copy of the Explanation of Benefits (EOB) to this form for reimbursement. For any claims not covered under your Plan (i.e. vision), attach a copy of the bill denoting patient name, provider, date of service, amount charged and amount paid.

NOTE: Do not send cancelled checks or statements That only indicates balance due. These do not contain the required information.

Dependent Care Expenses
Attach a receipt with names of child(ren), dates of service amount paid, provider, provider's tax I.D. or social security number.
NOTE: If your provider is a daycare center, a printout is acceptable. Their tax I.D. number must be included with each claim. If your provider is an individual and they have no tax I.D. number, we require a receipt, signed by the provider with the information mentioned above. **The providers social security number or tax I.D. number must be included on each claim.**
SSN or Tax I.D. number: ____________________________

* If you have elected automatic adjudication, do not use this form for any medical or dental claims. Eligible claims will automatically rollover to your flex account for reimbursement. You will use this form for prescriptions, over the counter drugs and daycare.

Over The Counter Drugs: For over the counter medications to be eligible expenses under the Plan, they must be for the diagnosis, prevention or treatment of a specific medical condition and not merely for the overall good health of the participant. Dietary supplements cosmetics and sundry items are not reimbursable. Please submit a cash register receipt (must indicate the specific name of the medication) and circle the eligible items for reimbursement

RXS: For reimbursement of prescription drugs you must submit the tag from the bag or a printout from the pharmacy. The tag or printout must contain the following information: patient name, date of service, drug name and cost.

Keep copies of supporting documentation for your records. We will not return what has been submitted.

Date Incurred	Claimant	Provider	Description of Expenses	Amount

The undersigned participant certifies that all expenses, for which reimbursement is claimed by submission of this form, were incurred during a period while the undersigned was covered under this Plan and that the expenses are for medical care of the participant and eligible dependents and not for the overall good health of the participant and depenednts. The undersigned fully understands that he alone is responsible for the sufficiency, accuracy and veracity of all information provided, and that unless an expense for reimbursement is a proper expense under the Plan, the undersigned may be liable for payment of Federal, State and City income tax on amounts paid from the Plan related to such expense. Any person who knowingly and with intent to defraud or deceive any Plan, files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime.

Date:________________________ **Employee Signature:** ____

Please return this form to:

CoreSource, Inc.
Attn: Flex Department
5200 Upper Metro Place, Suite 300
Dublin, Ohio 43017

Phone: 1-800-282-3920
Phone: 614-336-9604
Extension 208 or 216
Fax: 1-614-336-8428