FLEX HEALTH-MEDICAL CARE

SECTION 125 - REIMBURSEMENT CLAIM FORM

HOW TO FILE A CLAIM

1) For out-of-pocket insurance expenses (for example deductibles, co-insurance) copies of the Explanation of Benefits or worksheet from your Health/Dental plan(s).
NOTE: If you or a dependent are covered by two health plans, attach the Explanation of Benefits worksheet from both plans to claim the amount not paid by either plan.

2) For other items considered reimbursable by the IRS, copies of itemized receipts obtained from the provider of the services.

3) **Mail your claim to:** **IPMG Employee Benefits Services**
225 Smith Rd.
St. Charles, IL 60174
Phone: 630-789-2082

Fax: 630-203-4580

Website Submittal and/or E-mail:
www.ipmg.com/ebs

ABOUT YOU

Employer's Name _____

Your Name _____

Your Address _____

_____

Phone #/E-mail _____

Your Alternate-ID* or Social Security Number _____

*Your Alternate-ID is assigned by IPMG

HEALTH CARE INFORMATION

Patient: ☐ You ☐ Spouse Name:_____ Date of Birth:_____

☐ Dependent Name:_____ Date of Birth:_____

☐ Dependent Name:_____ Date of Birth:_____

Date of Service:	*Provider:*	*Type of Service:*	*Amount:*

PAYMENT AUTHORIZATION

I request payment from my Reimbursement Account for the expenses itemized above and attached.
I understand that the expenses reimbursed cannot be claimed on my personal income tax return.
I certify that all of these expenses have not and will not be paid by any other plan or program of any employer or other person.

Employee Signature _____ Date _____