LEXINGTON LOCAL SCHOOLS

REQUEST FOR REIMBURSEMENT
CAFETERIA PLAN SERVICES
UNREIMBURSED MEDICAL ACCOUNT

SUBMIT CLAIMS TO: TREASURER'S OFFICE ATTN: KATHY
OR FAX TO 419-884-3129

Employee Name (Please print): ______________________________

Social Security Number: ______________________________

Employee Address: ______________________________
City State

Unreimbursed Medical List Each Receipt Separately

Patient Name (A)	Provider Name (B)	Description of Service (C)	Date(s) Service Provided (D)	Requested Amount (E)	FLEX ONE Use Only

Please attach a third-party receipt, itemized bill or Explanation of Benefits (EOB) listing (A) (B), (C), (D) and (E) or have provider certify below. Canceled checks or bills showing only a previous balance or balance due are not acceptable.

PROVIDER'S CERTIFICATION/VERIFICATION

I certify that the above-described unreimbursed medical expenses were incurred by the employee named above.

____
Business/Provider Signature Address Date

I request reimbursement from my Flexible Spending Account as listed above and certify that these are eligible medical or dependent care expenses that I or my dependents have incurred. I understand that medical expenses must qualify as deductible expenses for federal income tax purposes, and cannot be reimbursed by any other source or used as a deduction on my personal income tax return9s0. I understand and agree that dependent care expenses must qualify for the dependent care tax credit and that I cannot claim the tax credit for expenses submitted hereunder. I also understand and agree that the taxpayer identification (Social Security) numbers of any dependent care service provider(s) will be supplied to the IRS on my annual tax return. I hereby authorize the Plan and its representatives to use the information provided above to administer the Plan (including the evaluation of eligibility for reimbursement under the Plan) and to detect or prevent fraud or misrepresentation and to further disclose any and all such information as is reasonably required for such purposes. I further authorize any provider, insurer, or other entity to release any health or treatment information for the purpose of determining eligibility for Plan benefits or to detect or prevent fraud. I hereby expressly waive and release any claims related to the use, disclosure or release of such information so long as the information is used in furtherance of administering the Plan (including the processing or evaluation of my claim for benefits under the Plan0, or detecting or prevent fraud. This authorization does not and is not intended to in any way limit any right the Plan, or their representatives may have under applicable state or federal law or regulation regarding the use of such information.

Date: ______________ Employee Signature: ______________________________