P.O. Box 21367 Billings, MT 59104-1367
Phone: 866.857.8182 Fax: 844.791.8315 Email: EBMS_receipts@alegeus.com

# Request for Flex/HRA Reimbursement

| Employer Name | | Employer Group Number |
|---|---|---|
| Employee's Last Name | First Name | Employee's ID Number |
| Address | | E-mail Address |

**Healthcare Expenses**

| Date of Service | Provider | Description of expense (office visit, co-pay, prescription, etc.) | Patient Name | Amount Requested |
|---|---|---|---|---|
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | **Total amount requested** | | $ |

**Dependent Daycare Expenses**

| Name of dependent | Date of birth | Daycare Provider Name & Tax ID number | Dates of Service | Amount Requested |
|---|---|---|---|---|
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | **Total amount requested** | | $ |

Participants must submit a copy of the receipt or bill for dependent care service detailing the name, address and tax ID/SSN of the provider, as well as dates of service being claimed. Receipts are not necessary if the provider has signed the Request for Flex Reimbursement Form.
*Note: The tax identification number or Social Security number of the provider is required on all submissions.*

**Daycare Provider's Signature:_____ Date: _____**

To the best of my knowledge and belief, my statements in the Request for Flex Reimbursement are complete and true.
I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. The expense(s) listed has not been reimbursed or is not reimbursable under any other health plan coverage and will not be claimed as an income tax deduction. I authorize my Flexible Spending Account be reduced by the amount requested above.

**Employee's Signature: _____ Date: _____**