# FLEXIBLE BENEFITS REIMBURSEMENT VOUCHER
# FIRST FINANCIAL ADMINISTRATORS, INC.

P O Box 670329, Houston TX 77267-0329
TELEPHONE: (800) 523-8422 • FAX: (281) 847-8425 or (800) 298-7785

## PARTICIPANT INFORMATION

Address Change? __ Y __ N

Name: _____
Mailing Address:_____
City/State/Zip: _____
Social Security #:_____ Daytime Telephone: (____)_____
Employer:_____ Email Address: _____

(COMPLETE ONLY for Dependent Care)

Name:_____
Address:_____
City/State/Zip:_____
S.S./Tax ID#_____

_____
Signature of Provider

(COMPLETE ONLY for Orthodontia Reimbursement)

Patient Name: _____
Amount Due: $_____ Date: _____
Service Performed: _____
*I certify that the dental procedure for the above patient*
❑ *has been completed* ❑ *is in progress*

_____
Signature of Dentist/Orthodontist

## BENEFIT TYPE: (please check as appropriate)

❑ Medical Reimbursement ❑ Dependent Care Reimbursement ❑ Premium Reimbursement

| Date of Service | Family Member | Description of Expense | Amount |
|---|---|---|---|
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| | | Sub-total this page: | |
| | | Grand total all pages | |

*I hereby affirm that, to the best of my knowledge, all expenses listed above are eligible for reimbursement under Section 105(h) or 129 of the IRS Code and in accordance with my contract with First Financial Administrators, Inc. I further certify that these expenses have not been, nor will not be reimbursed under any other health plan coverage. If you need verification of the eligibility of an expense, please contact First Financial Administrators, Inc. at 1-800-523-8422.*

**Signature:** _____ **Date:** _____

❑**Please send me additional envelopes (additional voucher given with every reimbursement)**

***NOTE: If you have direct deposit, First Financial Administrators, Inc. will not pay bank charges for insufficient funds. Please call your financial institution to verify deposit before writing any checks on the amount.***

**SEE BACK PAGE FOR ADDITIONAL ITEMIZATION & HELPFUL FILING TIPS**

## *REIMBURSEMENT ITEMIZATION CONTINUED*

| Date of Service | Family Member | Description of Expense | Amount |
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# VOUCHER INSTRUCTIONS

**Reimbursement checks will not be issued for a new plan year until we receive the first contribution from your employer!**

## DAYCARE SUBMISSION GUIDELINES:

**Acceptable Documentation** to accompany the reimbursement voucher:

1. Vouchers for Dependent Care signed by the Provider . Voucher must also be completed with the Provider's tax identification number or Social Security number and dates of service. ***or***
2. Voucher with receipt from Provider, including Provider name, Provider signature, dates of service, amount for service and tax identification / social security number.

***I.R.S. Regulations prevent us from reimbursing dependent care yearly contracts. Monthly submissions are required.***

## UNREIMBURSED MEDICAL SUBMISSION GUIDELINES:

**Acceptable Documentation** to accompany the reimbursement voucher:

1. Professional bill or receipt that includes:
   a. Provider of service
   b. **Type of service rendered**
   c. Original date of service
   d. Charges for the service
2. Insurance company Explanation of Benefits
3. Pharmacy statement that includes Rx number and name of the prescription

Make sure your attached receipt(s) has detailed description of service printed on it!

**Unacceptable Documentation:**

1. Cancelled checks / Credit card receipts.
2. Bill or receipt that only shows a balance forward or a previous balance.
3. Cash register receipt.

**NOTE: It is important to note that the date of the service, NOT THE DATE OF PAYMENT, must fall within the dates of the plan year for which you are enrolled.**