Medical Mutual
MZ: 44-2W-8317
2060 East Ninth Street
Cleveland, Ohio 44115-1355
Phone Number: (800) 525-9252
Fax Number: (440) 878-4890

Healthcare Flexible Spending Account (FSA) Expense Claim Form (Limited or Full-Purpose)

Instructions

Complete as many entries as you need for unreimbursed medical expenses, then sign and date the bottom of the form. Send completed form along with a fully detailed receipt or Explanation of Benefits (EOB) that contains the date of service, description of services, patient name, provider name, amount charged and any amount paid by insurance (if applicable). You can fax the completed form to (440) 878-4890 or mail it to the address above. If you have questions, please call Customer Care at (800) 525-9252. We are available Monday through Friday from 8 a.m. to 5 p.m. Please feel free to make copies of this form for future use.

General Information

Employer	Employee Name	Phone Number

Healthcare FSA Expense Claims (Attach appropriate receipt(s) and submit with this claim form if applicable.)

Date of Service	Name of Service Provider	Name of Service Recipient	Net Amount
Service Description			
Date of Service	Name of Service Provider	Name of Service Recipient	Net Amount
Service Description			
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Service Description			
Date of Service	Name of Service Provider	Name of Service Recipient	Net Amount
Service Description			
Date of Service	Name of Service Provider	Name of Service Recipient	Net Amount
Service Description			
			Total Amount

Certification and Authorization

I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible expenses incurred by myself or an eligible dependent while I was a participant in the plan. I have already received these products and services and have not been previously reimbursed for these expenses and I will not seek reimbursement of these expenses from any other plan or party. In addition, the expenses for which reimbursement is sought will not be claimed as tax deductions on my personal tax return. I understand that if an expense is determined to be ineligible, I am responsible for reimbursing the plan(s) for any such expense or for payment of all related income taxes on amounts paid from the plan(s) which relate to such expense. If I am covered under more than one health care account, reimbursement will be made according to the payment order determined by those plans.

Employee Signature	Date