Employee Name:				
Company/Employer Name:				
Social Security Number (or Employee ID, If Applicable):				
Email:	New Email:	Yes	or	No
Phone:				

Advanced Benefit Strategies

Your Flexible Benefits Specialists

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All documentation must be attached and include:

• Name and address of provider • Date of service • Services rendered on that date • The portion of charges you are responsible for

Credit card receipts/statements, Cancelled checks, & Balance forward statements aren't considered acceptable forms of documentation by the IRS.

HEALTHCARE			TRANSIT		
Date:	Type (RX, co-pay, contact solution, etc.)	Cost:	Date:	Transit Provider:	Cost:
HEALTHCARE TOTAL:		TRANSIT TOTAL:			

DEPENDENT CARE			PARKING			
Date:	Dependent(s) Name:	AGE:	Cost:	Date:	Garage/Parking Facility:	Cost:
				_		
				-		
				┨		
				-		
DEPENDENT CARE TOTAL:			PARKING TOTAL:			

I certify that the above reimbursement submissions are for eligible expenses incurred for my spouse, eligible dependent or myself. I will not receive payment from any other source for any of these expenses. If I am enrolled in an HSA I am submitting for only vision and or dental claims or medical expenses after IRS minimum deductible is met.

SIGNATURE: _____

DATE: _____

OVER THE COUNTER MEDICATIONS MAY BE SUBMITTED FOR REIMBURSEMENT. VITAMINS & SUPPLEMENTS, TEETH WHITENING PRODUCTS AND WARRANTIES ARE SAMPLES OF EXPENSES THAT ARE <u>NOT</u> ALLOWED AS THEY ARE CONSIDERED NOT MEDICALLY NECESSARY BY THE IRS.

View our website, <u>www.abs125.com</u> for complete description of eligible/ineligible items or shop at <u>www.fsastore.com</u> for your medical needs.