SCHOOL DISTRICT OF WESTFIELD

REQUEST FOR REIMBURSEMENT

Employee Name (please print) ______________________________ Date _____________________

Health Flexible Spending Account (Health FSA)

List each receipt separately. Use additional forms if necessary. Staple receipts to back in order listed.

Patient Name	Provider Name	Description of Services	Date Service Provided	Requested Amount
			TOTAL	$

Use the Provider Certification below **only if no receipt is attached**.
Provider Certification: I certify that the Participant named above incurred the Health Care expenses listed above.
Provider Address: Street_____________ City ________________ State _____ Zip ___________
Provider Signature _____________________________ Date ________

Information and Signatures

By submitting this claim form, I request reimbursement from my Flexible Benefit Plan as listed above. I agree to the Terms and Conditions of the Flexible Benefit Plan Document. I certify that these are eligible medical expenses that my dependents or I have incurred and that they have not and will not be reimbursed from another source. (e.g. health insurance, another employer's FSA)

Employee Signature ____