EBMS
Employee Benefit Management Services, Inc.
P.O. Box 21367 • Billings, MT 59104-1367
Toll Free 1-866-857-8182 • (406) 869-6526
Toll Free Fax 1-877-236-9868 • Email: flex@ebms.com

REQUEST FOR FLEX REIMBURSEMENT

Please complete applicable spaces on this form, attach appropriate bills, and forward to EBMS. (Cancelled checks or balance due statements are not acceptable bills.)

❑ Check if address has changed

Employer _____ Group Number _____

Employee Name _____ Member ID # _____
Last First Middle

Home Address _____
Number/Street City State Zip

UNREIMBURSED MEDICAL EXPENSE CLAIMS

Date Incurred	Name of Service Provider	Expense Description	Person for Whom Incurred	Net Amount
		TOTAL MEDICAL CARE EXPENSE CLAIM		

DEPENDENT CARE EXPENSE CLAIMS

Name of Dependent(s)	Period Covered		Name, Address and Taxpayer Identification Number of Provider of Service	Amount Incurred
	From	To		
			TOTAL DEPENDENT CARE EXPENSE CLAIM	0.00

To the best of my knowledge, the statements made within this Request for Reimbursement are complete and true. I am claiming reimbursement for eligible expenses incurred during the applicable plan year by eligible plan participants. **The medical expense requested has not been reimbursed or is not reimbursable by any other health coverage and will not be claimed as an income tax deduction**. I authorize my Flexible Spending Account to be reduced by the amount requested.

Employee's Signature _____ Date _____

For Dependent Care Expenses, the following must be completed by the Daycare Provider:
To the best of my knowledge, I certify that the information above regarding dependent care expenses is complete and true.

Dependent Care Provider Signature _____ Date _____