MEDICAL FLEXIBLE SPENDING ACCOUNT

Reimbursement Claim Form

EMPLOYEE NAME: _____

ADDRESS: _____

_____

_____

EMAIL: _____

SOCIAL SECURITY NO. _____

CELL PHONE: _____

WORK PHONE: _____

EMPLOYER: _____

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:** _____

UNREIMBURSED MEDICAL EXPENSES (MEDIFLEX)

Date Expense Incurred	Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
**Attach appropriate receipt(s) and submit with this claim form.			**Total Medical Expense Claim**	

FAX OR EMAIL CLAIMS TO:

3P Benefit Solutions

Fax: 601-715-1855

cliams@3pbenefits.com

***Claims may also be filed and uploaded via Participant Portal via www.3pbenefits.com or by Apple/Android app 3P Benefits**