

**BAINBRIDGE COLLEGE**  
Request for reimbursement of health care expenses  
*Prepare one claim form per individual*

Plan Year to which  
Claim Applies: \_\_\_\_\_

<b>Employee's Name:</b> _____		<b>Social Security Number:</b> _____	
<b>Claim Information:</b> Claim is for _____ Self _____ Dependent (If for dependent, complete section below.)			
<b>Dependent's Name</b>	<b>Date of Birth</b>	<b>Relationship</b>	<b>Full-time Student (Y/N)</b>

**RECEIPTS AND ALL APPLICABLE INSURANCE COMPANY EXPLANATION OF BENEFITS FOR MEDICAL EXPENSES MUST BE ATTACHED** (Please list fees beside each item.)

Amount	Description	Date of Service	Amount	Description	Date of Service
_____	1. Deductible	_____	_____	11. Non-educational treatment developmental disabilities	_____
_____	2. Routine physical or checkup	_____	_____	12. Educational treatment in IRC 213 qualified school (Special school for mentally/physically handicapped persons)	_____
_____	3. Routine hearing care	_____	_____	13. Fitness Program (smoking cessation, weight loss, ect.) prescribed by a physician for a specific ailment; not for your general health (attach physician's instructions)	_____
_____	4. Palliative/cosmetic foot care	_____	_____	14. Other...(Please describe)	_____
_____	5. Non-medical ancillary services long-term rehabilitation services	_____	_____		
_____	6. Co-insurance	_____	_____		
_____	7. Well baby care	_____	_____		
_____	8. Routine eye care	_____	_____		
_____	9. Medical/dental charges for non-participating provider	_____	_____		
_____	10. Charges in excess of reasonable & Customary allowances	_____	_____		
				<b>Total Amount of Reimbursement Requested</b>	_____

**CERTIFICATION**

I certify that the health care expenses being submitted for reimbursement meet the following requirements:

- The health care expenses were incurred by me or by eligible members of my family during the period I was a participant in Health Care Flexible Spending Account Plan. For purposes of the Plan, health care expenses have the same meaning as defined in Section 213 of the Internal Revenue Code.
- The health care expenses are not paid by the health care coverage provided through my employer or by any other policies, such as the coverage provided by my spouse's employer. The expenses submitted are not covered by any other policies or represent amounts not paid by such policies, such as deductibles or co-payments.

I understand that I have the responsibility for any tax reporting or other legal requirements with respect to reimbursed expenses. I also understand that to the extent health care expenses are reimbursed under the Health Care Flexible Spending Account, they cannot be claimed as expenses against the Federal income tax credit for health care expenses.

I authorize the release of any medical information necessary to process this claim. I attest that the expenses for which I am asking reimbursement have been paid by me.

**Employee's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Processed By**  
**(Payroll Office Representative)** \_\_\_\_\_ **Date** \_\_\_\_\_

**Reviewed By** \_\_\_\_\_ **Date** \_\_\_\_\_

**SECTION BELOW FOR ACCOUNTING USE ONLY**

Account number to be charged	Name of the account to be charged	Amount
	Spending Account- Health Care	