EBS-RMSCO, Inc.
Employee Benefit Solutions

Flexible Spending Account (FSA) Reimbursement Request Form

Employer Name

Participant First Name | MI | Last Name

Address

City | State | Zip Code

Email Address

Social Security Number / Member ID | Phone Number

Claimant Name	Date of Service	Amount	Type of Service	Claim Ref #	EBS–RMSCO Use Only
			❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx	01	
			❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx	02	
			❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx	03	
			❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx	04	
			❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx	05	
			❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx	06	
			❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx	07	
			❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx	08	

- Submit one expense (either product or service) per row, even if items are contained on the same receipt. Each item must be itemized and must have a corresponding receipt. Label receipts to correspond to "Claim Ref #". If you have more than 8 items to submit, use additional Reimbursement Request Forms. *Note: Please do not "lump" or group items together or write "see attached". EBS-RMSCO can only process claims that are properly submitted. Claims will be denied unless they are properly submitted.*
- For each claim, attach Explanation of Benefits (EOB), and/or itemized bill showing: date of service, provider name, patient name, charged amount and description. For Dependent Care, include the provider's tax id or SSN. **Do not send credit card receipts, original receipts or cancelled checks**.
- If covered by insurance, submit EOB or bill showing insurance payment.
- Please be sure to provide your SSN or Member ID.
- For faster reimbursement processing, submit your claims on-line at www.myebsaccount.com.
- All claims are subject to deadlines and minimum check amounts as defined in your Summary Plan Description (SPD).
- Call Customer Service with questions at 800-327-7130.
- Mail to EBS-RMSCO, Inc., FSA Dept, PO Box 2330, Blasdell, NY 14219; Fax# (877) 256-7228.

By submitting this form to EBS-RMSCO, Inc., I certify that the information here is true and correct, that the expenses incurred were for myself, spouse or qualified dependents and that these expenses are not reimbursable under any other plan coverage.