FSA REIMBURSEMENT CLAIM FORM

EMPLOYEE NAME: _____

EMPLOYER NAME: _____ LAST 4 SS#: XXX-XX-_____

PLEASE PRINT CLEARLY

PATIENT NAME	DOCTOR NAME / FACILITY NAME / PHARMACY NAME	SERVICE DATE / RX FILL DATE	TYPE OF SERVICE (MEDICAL, DENTAL, VISION, RX, OR OTC)	CLAIM AMOUNT
			Total:	**$**

ATTACH ALL EOB'S/STATEMENTS

By submitting this form to GMR Associates, Inc., I certify the information is accurate; the expenses incurred are for my spouse, qualified dependent(s) or myself. I certify these expenses are not reimbursable under any other plan coverage. I understand if I do not follow the instructions my reimbursement may be delayed or denied.

_____ _____

Signature of Employee Date

GMR ASSOCIATES | 2300 Buffalo Rd. Bldg. 600C, ROCHESTER NY 14624-0369 | FAX: 585-426-6981 | JLONTHAIR@GMR-USA.COM