maestro health

HEALTH CARE FSA
REIMBURSEMENT REQUEST FORM

INSTRUCTIONS:

1) Complete Employee Information requested in Section A
2) Complete Expense Information requested in Section B. Utilizing your receipts list each expense separately and attach the itemized receipts or the Explanation of Benefits to the back of the request form. Total the expenses on each form. Complete and attach additional request forms if necessary. Receipts or proof of payment must include:
   - The patient and provider name
   - The date of service
   - A description of the expense
   - The expense amount
3) Read the Employee Authorization in Section C carefully. Sign and date the request form.
4) Submit completed Reimbursement Request Form with attached receipts via:

Fax to: 844.306.8147

Website: msave.maestrohealth.com

Mail to: Maestro Health
FSA Administration
PO Box 2370
Matthews, NC 28106

Important:

- All medical, dental and vision expenses must be processed by your insurance carrier(s) first.
- To be eligible for a reimbursement the services must be incurred during the plan year regardless of when payment is made or expense is billed.
- Incomplete or unsigned request forms cannot be processed.
- Retain the original receipt/s or a copy of the claim and receipts for your personal records.

For assistance contact the FSA Service Center at: 888.488.5054

A: EMPLOYEE INFORMATION: (Please Print Clearly)

Employer/Company Name:	**Employee Last 4-digits of SSN:**
Employee Name:	**Phone Number:**

B: EXPENSE INFORMATION:

Patient Name	Provider Name	Description of Expense (Itemize each expense on a separate line)	Date of Service (mm/dd/yyyy)	Expense Amount
		☐ Medical ☐ Dental ☐ Vision ☐ Prescription ☐ Over The Counter ☐ Other: ________		$
		☐ Medical ☐ Dental ☐ Vision ☐ Prescription ☐ Over The Counter ☐ Other: ________		$
		☐ Medical ☐ Dental ☐ Vision ☐ Prescription ☐ Over The Counter ☐ Other: ________		$
		☐ Medical ☐ Dental ☐ Vision ☐ Prescription ☐ Over The Counter ☐ Other: ________		$
		☐ Medical ☐ Dental ☐ Vision ☐ Prescription ☐ Over The Counter ☐ Other: ________		$
		☐ Medical ☐ Dental ☐ Vision ☐ Prescription ☐ Over The Counter ☐ Other: ________		$
		☐ Medical ☐ Dental ☐ Vision ☐ Prescription ☐ Over The Counter ☐ Other: ________		$
			TOTAL SUBMITTED:	$

C: EMPLOYEE AUTHORIZATION:

I certify that I (and/or my eligible dependents) have incurred expenses for which reimbursement is sought under my Employer's Flexible Spending Account Plan and that these expenses have been incurred during the Plan Year. I further declare that I am requesting payment only for expenses that have not and will not be paid under any other benefit plan or program; and that I am solely responsible for the accuracy and veracity of all information relating to this claim. I authorize the Employer to reimburse the amount requested from my Flexible Spending Account.

______________________________________ **Employee Signature**

______________________ **Date**