Pre Tax Plan Reimbursement Request Form

Advanced Benefit Strategies

Your Flexible Benefits Specialists

www.abs125.com

Fax claims to: 860-673-2207
Mail claims to: Advanced Benefit Strategies
30 Mill Street
Unionville, CT 06085
Call: 860-675-2261 ▪ Toll Free: 877-732-8125

Employee Name:	
Company/Employer Name:	
Social Security Number *(or Employee ID, If Applicable)*:	
Email:	**New Email:** ◯ **Yes or** ● **No**
Phone:	

All documentation must be attached and include:

• Name and address of provider • Date of service • Services rendered on that date • The portion of charges you are responsible for

Credit card receipts/statements, Cancelled checks, & Balance forward statements aren't considered acceptable forms of documentation by the IRS.

HEALTHCARE

Date:	Type (RX, co-pay, contact solution, etc.)	Cost:
	HEALTHCARE TOTAL:	$0.00

TRANSIT

Date:	Transit Provider:	Cost:
	TRANSIT TOTAL:	$0.00

DEPENDENT CARE

Date:	Dependent(s) Name:	AGE:	Cost:
	DEPENDENT CARE TOTAL:		$ 0.00

PARKING

Date:	Garage/Parking Facility:	Cost:
	PARKING TOTAL:	$0.00

I certify that the above reimbursement submissions are for eligible expenses incurred for my spouse, eligible dependent or myself. I will not receive payment from any other source for any of these expenses. If I am enrolled in an HSA I am submitting for only vision and or dental claims or medical expenses after IRS minimum deductible is met.

SIGNATURE: _____ **DATE:**

ALMOST ALL OVER THE COUNTER MEDICATIONS REQUIRE A DOCTOR'S NOTE OF MEDICAL NECESSITY TO BE ON FILE WITH US. NOTE MUST INCLUDE PROVIDERS NAME AND ADDRESS, PRODUCT LISTED BY NAME, SPECIFIC MEDICAL CONDITION OR DIAGNOSIS THAT EACH PRODUCT WOULD BE TREATING.

View our website, ***www.abs125.com*** *for complete description of eligible/ineligible items or shop at* ***www.fsastore.com*** *for your medical needs.*