



**MEDICAL Flexible Spending Account**  
*Request for Reimbursement*

**BCPS**

**SECTION A: Employee Information** (please print clearly in ALL CAPITAL letters)

**Plan Year: 9.01.09 – 8.31.10**

Name: \_\_\_\_\_ Employee ID: \_\_\_\_\_  
(FIRST NAME LAST NAME) (This may be your SSN or employer assigned number)

Employer: **Baltimore County Public Schools**

Email: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Check here if new address

**SECTION B: Claim information and Signature**

**PLEASE READ CAREFULLY:** I certify that the expenses listed below have been incurred by me, my spouse and/or my eligible dependents during the plan year and while I was a participant in the plan. To the best of my knowledge all expenses below are eligible under the plan. I certify that any prescriptions drug expenses are for medical care and not cosmetic purposes. I understand that I am responsible for the accuracy of the information related to this expense. I have not and will not seek to be reimbursed through any other health plan coverage for any of the expenses listed below. I further declare that I will not deduct any of the reimbursed medical expenses listed below from my federal, state or local tax returns.

Total amount of this claim requested: \$ \_\_\_\_\_ Number of pages sent (do NOT fax a cover sheet): \_\_\_\_\_

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION C: Medical Claim details** (please print clearly in ALL CAPITAL letters)

- 1) Provider: \_\_\_\_\_ Date of Service: \_\_\_\_\_ Amount: \_\_\_\_\_
- 2) Provider: \_\_\_\_\_ Date of Service: \_\_\_\_\_ Amount: \_\_\_\_\_
- 3) Provider: \_\_\_\_\_ Date of Service: \_\_\_\_\_ Amount: \_\_\_\_\_
- 4) Provider: \_\_\_\_\_ Date of Service: \_\_\_\_\_ Amount: \_\_\_\_\_
- 5) Provider: \_\_\_\_\_ Date of Service: \_\_\_\_\_ Amount: \_\_\_\_\_
- 6) Provider: \_\_\_\_\_ Date of Service: \_\_\_\_\_ Amount: \_\_\_\_\_
- 7) Provider: \_\_\_\_\_ Date of Service: \_\_\_\_\_ Amount: \_\_\_\_\_
- 8) Provider: \_\_\_\_\_ Date of Service: \_\_\_\_\_ Amount: \_\_\_\_\_

TOTAL AMOUNT OF MEDICAL REIMBURSEMENT REQUESTED: \$ \_\_\_\_\_

**FAX THE CLAIM TO:**

**888-510-4218**

or EMAIL TO:

Claims@hfsbenefits.com

If mailing, please keep the originals for your records.

Mailed claims can be sent to:

PO Box 1550

Hunt Valley, MD · 21030-1550



**BEFORE SENDING MAKE SURE YOU ...**

- Complete this form in its entirety. Failure to complete all sections can result in a delay in processing your reimbursement.
- Itemize all expenses on the claim form. List the provider name, date of service (the date the service was INCURRED), and the amount of each expense. Please use additional sheets if necessary. Do NOT indicate 'See attached' or 'Various' in any field.
- Attach proof of expense (invoice, receipt, EOB, etc.) in the order you have them listed above.
- Receipts, invoices, etc. must show the date, type and amount of service/product purchased.
- Circle the date and the amount requested on each receipt. Do NOT highlight.



**BEFORE SENDING MAKE SURE YOU DO NOT...**

- Send in cancelled checks or credit card receipts. These are NOT acceptable.
- Send in a receipt listing 'BALANCE DUE' or 'BALANCE FORWARD'.
- Fax in your claim multiple times.

View your account online at [www.hfsbenefits.com](http://www.hfsbenefits.com)