MERITAIN HEALTH
An Aetna Company

Mail completed form to:	**Meritain Health P.O. Box 30111 Lansing, MI 48909**
Fax to:	**888.837.3725**
Customer Service:	**800.566.9305**

REIMBURSEMENT REQUEST FORM

Employer Name: Saint Mary's College

Employee Name: _____ **SS# or ID#:** _____

Address: _____ **Telephone #:** _____

City: _____ **State:** _____ **Zip:** _____ **Is this a change of address?** ❑ Y or ❑ N

Select account from which you are requesting reimbursement, and fill out all requested information completely.
For further instructions, see Guidelines for Reimbursement *on the back of this form.*

❑ Flexible Spending Account (FSA)

Date of Service	**Name of Provider** (e.g., physician, hospital, dentist, pharmacy)	**Type of Service** (e.g., copay, Rx, ortho)	**Name of Patient**	**Amount of Expense**	Was this service covered by any insurance plan?
				$	Y / N
				$	Y / N
				$	Y / N
				$	Y / N
				$	Y / N
			Total amount requested from your **FSA:**	$	

If more space is needed, list additional requests on a separate page. Please include all requests in the total.
A minimum request amount (as established in your plan document) may need to be met before a claim can be paid.

❑ Dependent Care Account (DCA)

Name of Day Care Provider	**Dates of Service**		**Dependent's Name**	**Date of Birth**	**Amount of Expense**
	From	**To**			
					$
					$
					$
				Total amount requested from your **DCA**:	$

Provider Signature: _____ **Provider SSN# or Tax ID:** _____

Signature not required if signed receipt or Day Care Center statement is attached. Altered receipts cannot be accepted.

I certify that I have actually incurred these eligible expenses. I understand that *expense incurred* means that the service has been provided that gave rise to the expense, regardless of when I am billed or charged for, or pay for the service. The expenses have not been reimbursed or are not reimbursable from any other source. I understand that any amounts reimbursed may not be claimed on my or my spouse's income tax returns. I have received and read the printed material regarding the reimbursement accounts and understand all of the provisions.

Employee Signature: _____ **Date**: _____