Great-West℠ HEALTHCARE

Flexible Spending Account (FSA) Reimbursement Form

Please complete this form and mail or fax with supporting documentation to:
Great-West Healthcare, Flexible Benefits Administration - PO Box 1080 - Denver - CO - 80201, **or** fax # 303-737-5248. Our Customer Service Representatives are available 7am to 5pm Mountain time at 800-759-4952. One claim form per request.

Employer Name: _____ Group/Plan Number: 050703

Employee Name: _____ Social Security Number: _____

Employee Mailing Address: _____ Phone #: _____

City/State/Zip Code: _____ Address Change? Yes ☐ No ☐

Health Care Expenses **(all information must be completed): Please attach itemized receipts or EOB statements for the below services.**

Date of Service	Provider	Patient	Description of Service	Requested Amount
___/___/___				
___/___/___				
___/___/___				
___/___/___				
___/___/___				
___/___/___				

Total Amount Requested from Health Flexible Spending Account (Required) $_____

Dependent Care Expenses **(all information must be completed): (Day Care Provider MUST sign form OR itemized receipts MUST be attached.)**

Name of Day Care Provider: _____

Address of Day Care Provider: _____

Tax ID Number **OR** Social Security Number of Day Care Provider: **(Required)** _____

Signature of Day Care Provider: _____

Dependent's Name	Date of Birth	Relationship	Dates of Service From	Dates of Service To	Requested Amount
	___/___/___		___/___/___	___/___/___	
	___/___/___		___/___/___	___/___/___	
	___/___/___		___/___/___	___/___/___	

Total Amount Requested from Dependent Care Flexible Spending Account (Required)$_____

Employee Certification for Reimbursement:
I certify that I (and/or my spouse and/or eligible dependents) have incurred the expenses for reimbursement from my FSA. These expenses were not reimbursed, and are not reimbursable by any other benefit plan. To the best of my knowledge and belief, these expenses are eligible for reimbursement under my FSA. I (we) will not claim the expenses reimbursed through my FSA as deductions or credits when filing my (our) tax return.

Employee Signature: _____ Date: _____/_____/_____
(Signature Required)

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