# Medical Expense Flex & HRA Reimbursement Request Form

| Employee Information | |
|---|---|
| **Name** | **Social Security Number** |
| **Email Address** | **Phone Number** |

**Please insert one or both codes below:**

**H: HRA REIMBURSEMENT REQUEST**

**F: MEDICAL EXPENSE/FLEX REIMBURSEMENT REQUEST**

☐ **The attached documentation is for a claim that was submitted at www.cdscpa.com.**

| Code | Date of Service | Person Incurring Expense | Relationship | Provider | Description of Service | Amount Requested |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | Total Amount of Flex Reimbursement Requested | |
| | | | | | Total Amount of HRA Reimbursement Requested | |

- I request reimbursement for the attached expenses under my employer's flexible benefits plan and/or HRA.
- I certify that I, or my eligible dependents, have incurred these expenses while I was covered under the Plan.
- If the expenses are covered under health or dental insurance, attached is an Explanation of Benefits (EOB) which shows that the insurance company did not pay for this expense because of deductibles, co-payments or non-allowed charges.
- Furthermore, I declare that these expenses have not been reimbursed from any other source nor do I expect them to be.
- I certify that these expenses are for medical expenses as defined by Section 213 of the Internal Revenue Code and will not be claimed as a deduction on my personal income tax return.

_____ _____

Employee Signature Date

Change of address? ☐ No ☐ Yes New Address: _____

CDSA
CDS ADMINISTRATIVE SERVICES

**P** (320) 214-2909 **| E** benefits@cdscpa.com **WILLMAR:** PO Box 570 **SARTELL:** 2351 Connecticut Ave, Ste 110
**F** (320) 235-0988 **| W** www.cdsatpa.com Willmar, MN 56201 Sartell, MN 56377