LIMITED MEDICAL EXPENSE REIMBURSEMENT FORM

(FOR REIMBURSEMENT OF DENTAL, VISION AND PREVENTIVE CARE EXPENSES)

To ensure timeliness in processing, please fill out claim form completely and accurately, sign, date, and attach an itemized statement or Explanation of Benefits which includes Description of Service, Date of Service, and Amount owed (after insurance has paid their portion).

PLEASE CHECK ONE OF THE FOLLOWING:

- ☐ **Documentation attached is for this manual claim form.**
- ☐ **Documentation attached is for a claim submitted online via www.cdsatpa.com.**
- ☐ **Documentation attached is for purchases made with my Benefits Card.**

Employee Information		
Employee Name		**Social Security Number**
Company Name	**Email Address**	**Phone Number**

Date of Service	Person Incurring Expense	Relationship	Provider	Description of Service	Amount Requested
				Total Amount of Reimbursement Requested	

I request reimbursement for the attached expenses under my employer's flexible benefits plan.
I certify that:

- I, or my eligible dependents, have incurred these expenses during this plan year.
- I understand that I am responsible to provide necessary documentation to substantiate the expense is eligible. 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.
- These expenses have not been reimbursed from any other source nor do I expect them to be.
- 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

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