Don't forget you can submit claims for reimbursement through the participant portal at www.mywealthcareonline.com/flexsave

FLEXSAVE Of America, Inc.
Consumer Driven Healthcare Solutions

RESET

Reimbursement Form

Last Name: _____ First Name: _____ Last Four Digits of SSN#: ____

Street: _____ City: _____ State: _____ Zip: _____

Employer: _____ Email: _____ Phone: ___ - _____

Health Care Reimbursement Worksheet

DOS Start Date	DOS End Date	Recipient	Provider/ Merchant Name	Dollar Amount
			TOTAL	$0.00

Day Care Reimbursement Worksheet

Day Care Start Date	Day Care End Date	Name of Child	Name of Provider	Dollar Amount
Provider Tax ID or SSN#:			**TOTAL**	$0.00

Signature of Child Care Provider:_____ or send billing/invoice statement.

Preferred method of reimbursement (check one) ☐ CHECK ☐ DIRECT DEPOSIT

Please include bank information for direct deposit: **Please leave blank if we already have your banking information**

We only need bank information once. account # _____ routing # _____

I request reimbursement from my account. I certify that the information provided is true and correct, that these expenses are not and will not be covered by any insurance program or other reimbursement program, and that I have not nor will not claim these expenses as income tax deductions on my income tax return, and that the expenses submitted qualify as required. I also understand that the Internal Revenue Service (IRS) may require proof that these are eligible expenses, and that I am responsible for providing such proof.

Check Box for Electronic Signature ☐ DATE: __ / __ / ____

you agree to the terms above by checking this box

Please send this form along with your documentation to: **FlexSave of America, Inc. ● 22811 Greater Mack ● Suite 201 ● St. Clair Shores ● MI. ● 48080 or fax to (866) 893-3266**

PRINT

Additional Health Care Claims Worksheet (if needed)

DOS Start Date	DOS End Date	Recipient	Provider/ Merchant Name	Dollar Amount
			TOTAL	$0.00

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Mileage Reimbursement Worksheet

When requesting reimbursement for mileage, you will need to complete this form in its entirety. For each visit you are requesting mileage for, you will need to provide information related to the trip such as round trip mileage and the receipt that shows the date of service and the providers address.

Eligible mileage would include trips to the:

- Hospital
- Doctor's Office
- Dentist
- Ophthalmologist
- Optometrist
- Chiropractor

Mileage Reimbursement Rates

2017 = $.17 cents per mile driven
2018 = $.18 cents per mile driven

Date of Service	Providers Name	Roundtrip Mileage Total	Based on the grid above, please indicate the mileage rate	Total Dollar Amount Submitted
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
			TOTAL	$0.00

ALMOST FINISHED! Now take the TOTAL dollar amount you're submitting and include it as a line item on the reimbursement form. For each patient or member of your family that's included on this form, they should be listed separately on the reimbursement form but you can include multiple dates of service on one line. See below for example:

DOS Start Date	DOS End Date	Recipient	Provider/Merchant Name	Dollar Amount
01/01/2018	03/01/2018	John	St. John Hospital	$100.00
01/15/2017	02/01/2017	Jane	John Smith, DDS	$125.62