FLEXIBLE SPENDING ACCOUNT
REIMBURSEMENT REQUEST

Please send your claims to: Benefit Coordinators Corporation (BCC)
Mail: Two Robinson Plaza, Suite 200 Pittsburgh, PA 15205-1324 | Fax: 412-276-7185 | Download: https://secure.benXcel.com
You may also scan/convert your documents to a PDF file and e-mail to: fsa-claims@benxcel.com.
(NOTE: The file size of your e-mail attachment cannot exceed 5MB.)

Visit our homepage at www.benXcel.com for easy-to-access forms! | BCC's Customer Service Center: 1-800-685-6100

EMPLOYER: City of Merced	GROUP NUMBER: CTYMER	Number of Pages (including receipts): _____
EMPLOYEE NAME: _____		Last Four Digits of SSN: _____

YOUR ADDRESS: ☐ Please check if this is a change in address since you last submitted a claim.

_____
Street

_____ _____ _____
City State Zip

NOTE: If your request is missing any vital information, BCC will send you an Explanation of Benefits (EOB) denying your request with an explanation of the additional information necessary to complete the reimbursement process. Also, it's imperative you sign your form to avoid having your request denied. For a detailed explanation of how to submit a claim for reimbursement, visit www.benxcel.com and read "Submit healthcare claim" and "Submit dependent claim" under our Forms and Brochures section. Please include copies of ALL receipts and documentation with this form.

HEALTH CARE ACCOUNT EXPENSES

If a health care charge is eligible for full or partial reimbursement from an insurance carrier, the charge must be submitted to all applicable insurance carriers before this plan can make payment. Once the claim has been processed by your insurance carrier, attach your Explanation of Benefits statement (EOB) with an itemized receipt. If the charge does not need to be submitted to the insurance carrier (office visit copays, prescription copays, eligible over-the-counter drugs, etc.) attach your itemized receipt. Do not attach checks or credit card receipts, as the IRS does not recognize these items as valid receipts for this program.

DATE OF SERVICE	NAME OF SERVICE PROVIDER	EXPENSE DESCRIPTION	RECIPIENT OF SERVICE	RELATIONSHIP TO EMPLOYEE	NET AMOUNT
					$
					$
					$
					$
					$
					$
					$
				TOTAL (required):	$

DEPENDENT CARE ACCOUNT EXPENSES

Attach a copy of the invoice and receipt. Provider's signature is required if there is not a receipt attached.

Provider Name: _____ SS# / TIN#: _____
Address: _____
City: _____ State: _____ Zip: _____

Dependent Name	Dependent Date of Birth:
Date(s) of Dependent Care Coverage: _____ Total Claim: _____	Provider Signature (In lieu of receipt): _____

To the best of my knowledge and belief, my statements in this Request for Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan, and will not be claimed as an income tax deduction. I authorize my Flexible Spending Account to be reduced by the amount requested.

_____ _____
EMPLOYEE SIGNATURE (Required) DATE