# Request for Healthcare Reimbursement Expenses

**Return completed form to:**
J.J. Stanis & Company, Inc.
377 Oak St, Suite 406
Garden City, NY 11530
Email: claims1@jjstanisco.com
Fax Number 516-465-3920

Employer _____ Group Number _____

Employee Name _____ SS No. _____
Last First Middle

Home Address: _____
Number/Street City State Zip

☐ Please check only if this is a new address. Daytime Telephone Number _____

## HEALTH CARE FLEXIBLE SPENDING ACCOUNT

**Check the box that applies. Supporting documentation as required by the IRS, applicable laws and/or your Plan must accompany this reimbursement request form.**

☐ **I have group health (medical, dental, vision) insurance for this expense.** Attach a copy of the Explanation of Benefits (EOB) statement that you received from your insurance carrier showing how benefits were paid.

☐ **I do NOT have insurance coverage for this expense.** Submit an itemized statement showing the date of service, provider's name, and services Provided, and the amount of the charge.

☐ **I belong to an HMO.** Submit a paid receipt for your copayments. For expenses not covered, submit an itemized statement.

☐ **I am submitting expenses for orthodontia.** With your first request, submit a copy of the Truth in Lending Statement (contract) itemizing the treatment period, down payment and monthly payments, and the amount covered by insurance, if any. Submit a copy of your monthly payment coupon and/or itemized receipt each time you request reimbursement for ongoing treatment.

| Date of Service | For the Benefit of (Name and Relationship) | Description of Service | Provider of Service | Requested Amount |
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I certify that I have not previously requested reimbursement for the above expense under this plan or any other plan, and I am not eligible to receive additional insurance benefits or reimbursements from any other source for such expenses. I further certify that I am not applying these expenses toward any federal or state income tax deduction or credit.

Employee Signature: _____ Date: _____

If you have questions about a claim, or the FSA program, please call **(516) 465-3900** between 8:30 a.m. and 5:00 p.m. ET, Monday through Friday.