Clear Form

MBA
THE OPEN SOLUTION™

REIMBURSEMENT VOUCHER

FLEXIBLE SPENDING
alternatives
alternatives
alternatives

MBA Benefit Administrators
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Employee Name:		**Company Name:**	
Address:		**City, State, ZIP:**	
ID Number:		**Date Submitted:**	

☐ Change Address Request

NOTICE:
Participating employees are required to supply PROOF of claims to the Administrator.
MEDICAL CLAIMS: Itemized bills or explanation of benefits are required for medical reimbursements. Reimbursement requests for supplies, equipment and travel must be properly documented with third party receipts and prescriptions when necessary.
DEPENDENT CARE CLAIMS: Receipts are required for each claim. A Dependent Care Authorization Form must be on file for each childcare provider.

Medical, Dental or Vision Out-of-Pocket Expenses (See eligible expense list for more detail)

Date Incurred	Patient	Services/Provider	Amount

TOTAL MEDICAL: $ 0.00

Child Care Expenses (Include Dependent Care Authorization Form if provider has changed)

Date Incurred	Patient	Services/Provider	Amount

TOTAL DEPENDENT CARE: $ 0.00
TOTAL REIMBURSABLE EXPENSE: $ 0.00

The Administrator will rely upon information provided by the participating employee and shall not be liable for the completeness or truth of any information supplied.

I certify under penalty of perjury that the medical expenses submitted have not or will not be reimbursed or are not reimbursable under any other health plan coverage. I certify this claim is an allowable expense for myself or my legal eligible dependent as defined in IRC Section 152.

Participant's Signature:_____ Date:_____

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BENEFIT ADMINISTRATORS