Flexible Spending Account

mySourceCard Debit Card Substantiation Request Form

Employer Name:		**SSN:**	
Employee Name:		**Phone:**	
Employee Address:			
Email Address:			

☐ Please check if this is a new address

Please read the Reimbursement Account Rules and Claim Filing Instructions provided online before completing this claim.

Please include copies of applicable receipts with this request.

**Information below must be completed*

Healthcare Expenses (Medical, Dental, Vision and OTC Medications)						
***my*SourceCard Transaction**		**Date of swipe**	**Dates of Service**	**Patient Name**	**Description of Service**	**Swipe Amount**
☐ Yes	☐ No					
☐ Yes	☐ No					
☐ Yes	☐ No					
☐ Yes	☐ No					
☐ Yes	☐ No					
☐ Yes	☐ No					
☐ Yes	☐ No					
☐ Yes	☐ No					
☐ Yes	☐ No					
☐ Yes	☐ No					
☐ Yes	☐ No					
☐ Yes	☐ No					
☐ Yes	☐ No					
					Total:	$0.00

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement indicated on this substantiation form were incurred by me (and/or my spouse and/or my eligible dependents), and were not reimbursed by any other plan nor will I seek reimbursement from any other source. To the best of my knowledge and belief, the expenses are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed though this account as deductions or credits when filing my (our) individual income tax return. Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement or claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ **Date:** _____

FOR FASTEST PROCESSING, FAX TO: (616) 454-6090 OR (616) 454-9862
Or mail to:
Flex Administrators, Inc.
77 Monroe Center NW
Suite 1100
Grand Rapids, MI 49503-2911
claims@flexadministrators.com

Revised 7.28.08