



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
<b>TOTAL</b>				

**Day Care Reimbursement Worksheet**

Day Care Start Date	Day Care End Date	Name of Child	Name of Provider	Dollar Amount
<b>Provider Tax ID or SSN#:</b>			<b>TOTAL</b>	

**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**  
*you agree to the terms above by checking this box*

**DATE:**                      /                      /

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**





## 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

<b>RATE</b>
2013 = \$.24 cents per mile
2014 = \$.23.5 cents per mile

Date of Service	Providers Name	Roundtrip Mileage Total	Based on the grid above, please indicate the mileage rate	Total Dollar Amount Submitted
			<b>TOTAL</b>	

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
01/01/2013	03/01/2013	John	MILEAGE	\$100.00
01/15/2013	02/01/2013	Jane	MILEAGE	\$125.62