Missoula County Risk & Benefits
200 West Broadway
Missoula, MT 59802
Phone (406) 523-4876
Fax (406) 523-4731
For additional forms, go to
http://www.missoulacounty.us/government/administration/risk-benefits

FLEX MEDICAL EXPENSE REIMBURSEMENT REQUEST

Please fill out the applicable spaces on this form, attach the appropriate documentation, and forward to Missoula County Risk & Benefits Department. If any of the expenses were covered by your insurance or any other insurance, an "**Explanation of Benefits**" must be submitted as documentation. For expenses not covered by insurance, send a copy of the provider bill or invoice identifying the service, service date, total charges and any discounts. **If the required documentation is not attached with this form, your reimbursement will be denied and returned to you.**

Plan Year: _____ Department _____ Daytime Phone# _____

Employee Name: _____ Soc. Sec. # _____

Last First

Home Address: _____

Street or Box Number City State Zip

UNREIMBURSED MEDICAL EXPENSE CLAIMS

Date(s) Incurred	Name of Provider, or Description of Service(s) Rendered	Covered by insurance?	Out-of Pocket Medical Expense(s)
		Yes ☐ No ☐	
		Yes ☐ No ☐	
		Yes ☐ No ☐	
		Yes ☐ No ☐	
		Total Medical Expenses (Minimum $10)	$

I certify to the best of my knowledge, the statements made within this Request for Reimbursement are complete and true. I certify the medical expenses were necessary to treat a medical condition for myself, my tax dependents, and/or spouse. I further understand that expenses reimbursed by Flex may not be claimed on my income tax return as an income tax reduction. I authorize my Flexible Spending Account to be reduced by the amount requested.

Employee's Signature _____ Date _____