Strategic Business Services
Medical Flexible Spending Account
Claim Form

Remit To:
SBS Claim Processing
7422 Carmel Executive Park Drive
Suite 212
Charlotte, NC 28226
FAX: 888-923-9977
Email: claimprocessing@125admin.com

Employee Information

Employer Name:		Daytime Phone:	
Employee Name:		SSN #:	
Employee Address:		Apt/Suite:	

City:		State:		Zip:		E-Mail:	

PLEASE NOTE: Claims that are not listed on this form cannot be processed. You must complete each field below for each claim you are seeking reimbursement for and attached supporting documentation.

Unreimbursed Medical Expenses *(Attach supporting documentation)*

Supporting documentation for unreimbursed medical expenses must include all of the following:

- ☐ Provider's name and address
- ☐ Patients name
- ☐ Service Description
- ☐ Amount Billed
- ☐ Date of Service

Date(s) of Service	Amount	Description of Service	Provider / Merchant Name	Name of Person Receiving Service
Calculate Total				

Employee Confirmation

I certify that the claims listed above are a true and accurate statement of all expenses incurred by my eligible dependents or me on the date(s) indicated, and were incurred while I was covered under the Flexible Spending Account(s). Supporting documentation from my service provider(s) for all expenses is attached to this claim form. I understand that I cannot claim any reimbursed expenses from the plan on my income tax return, and that I may be liable for payment of all related taxes including Federal, State, or City income tax and any associated penalties on the amounts paid for any expense improperly claimed under the provisions of the Flexible Spending Account(s).

Employee's Signature: _____ **Date Signed (mm-dd-yyyy):** _____

Internal Use Only: **Date Received:** _____ **Date Entered:** _____