DRIVEN 125
BENEFIT ADMINISTRATORS

CLAIM REIMBURSEMENT REQUEST FORM

Instructions: Please print or type and complete all items under **Personal Information**. In order to receive reimbursement, you must submit an *Explanation of Benefits Statement* (if applicable) from your insurance carrier, or an itemized statement that includes the provider name, patient name, date of service, description of service, insurance responsibility (if applicable), and patient responsibility for each health care claim. For dependent care reimbursement you have two choices: (1) Fill out all items in the **Dependent Care Expenses** section andattach a receipt of your payment, **OR** (2) Fill in your dependent's name, age, date of service and the requested amount, and have your DayCare provider fill out the **Affidavit of Dependent Care Provider**. You must sign and date this form and attach any corresponding receipts in order for us to process this claim. You have permission to photocopy this form.

PERSONAL INFORMATION

Employer's Name	**Email Address**
Employee's Name	**Date of Request**
Employee's Social Security Number	**Daytime Phone Number**

HEALTH CARE EXPENSES

Patient Name	Relationship	Age	Date of Service	Type of Service (Medical, Dental, etc.)	Requested Amount
1.					
2.					
3.					
4.					
5.					
6.					
				Total:	

DEPENDENT CARE EXPENSES

Dependent's Name	Age	Date of Service From	Date of Service To	Requested Amount
1.				
2.				
3.				
		Total:		

AFFIDAVIT OF DEPENDENT CARE PROVIDER

I have provided adult/child care for_____, age_____, for the period beginning _____
And ending_____. Services were provided by_____for a fee of $_____.

Signature of Provider	Tax ID# or SS	Date

I, the undersigned, hereby certify that the above listed expenses have not been previously reimbursed from my Flexible Spending Account, nor are reimbursable from any other source. I hereby authorize Driven Benefit Administrators to obtain necessary information from all physicians, hospitals, daycare providers, employers and all other agents in order to adjudicate the claim for reimbursement under the Benefit Plan established by my employer.

Employee Signature **Date**

DRIVEN BENEFIT ADMINISTRATORS
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