Medcom
BENEFIT SOLUTIONS

Don't want to fill out this form?
Submit your request for reimbursement online at https://Medcom.wealthcareportal.com or through our Mobile App! Just search "Medcom" in your app store!

Claim Form

Employee Name *(Print)* _____

Employee Social Security Number _____

Employer Name _____

YOUR CLAIM CANNOT BE PROCESSED IF THE FOLLOWING SUBSTANTIATION IS NOT ATTACHED

- **Medical Claims**: While the EOB is sufficient for FSA Claims, an itemized statement is also acceptable that includes the date of service, services rendered, total charges, and patient responsibility.

Please reimburse me for:

☐	**Expenses Totaling**	**$**	_____

Please remember that you may only submit requests for reimbursement from Medcom for the benefit plans we administer on behalf of your employer. Please login to your account online at to determine the benefit plans in which you are enrolled.

Expenses Incurred by (NAME)	**Check ✓**							
	Self	**Spouse**	**Child**	Date of Birth	**Provider of Service**	**Incurred Date**	**Itemize & Total Expenses**	**Reimburse Me From My FSA Plan**
					TOTAL SUBMITTED		**$**	

I hereby certify that the above requested reimbursement is for eligible services received by either myself or eligible tax dependents (if any). The above expenses are not payable to me or any eligible tax dependent(s) from any other source, nor will I seek reimbursement under any other plan or source covering health benefits. .

I further certify that I understand that I must immediately repay ineligible reimbursements. If I have a debit card, it will be deactivated until the full amount of any ineligible expenses is repaid; and, future claims may be offset; or, at my employer's discretion, ineligible expenses may be payroll deducted from my paycheck. Additionally, because unsubstantiated expenses are considered ineligible expenses by IRS regulations, I understand that I am required to keep and submit receipts to substantiate expenses as requested by the claims administrator. And, I understand that funds I repay the Plan for ineligible expenses may be used for reimbursement to me for eligible expenses incurred during the applicable Plan Year.

Employee Signature _____ Date _____

Would you like this and future reimbursements direct deposited into your bank account? Sign up for direct deposit by completing the Direct Deposit Authorization form available at and submit to Medcom along with a copy of a voided check.

Contact us:
(800) 523-7542
www.medcombenefits.com
MedcomReceipts@medcombenefits.com