

FLEXIBLE BENEFITS REIMBURSEMENT VOUCHER

FIRST FINANCIAL ADMINISTRATORS, INC.

P O Box 670329, Houston TX 77267-0329
 TELEPHONE: (866) 853-3539 • FAX: (800) 298-7785

PARTICIPANT INFORMATION

Address Change? Y N

Name: _____
 Mailing Address: _____
 City/State/Zip: _____
 Social Security #: _____ Daytime Telephone: (____) _____
 Employer: _____ Email Address: _____

(COMPLETE ONLY for Dependent Care)

(COMPLETE ONLY for Orthodontia Reimbursement)

Name: _____
 Address: _____
 City/State/Zip: _____
 S.S./Tax ID# _____

Patient Name: _____
 Amount Due: \$ _____ Date: _____
 Service Performed: _____

I certify that the dental procedure for the above patient
 has been completed *is in progress*

 Signature of Provider

 Signature of Dentist/Orthodontist

BENEFIT TYPE: (please check as appropriate)

Medical Reimbursement Dependent Care Reimbursement Premium Reimbursement

Date of Service	Family Member	Description of Expense	Amount

Sub-total this page:

Grand total all pages

ADDITIONAL FORMS AVAILABLE AT:
www.ffga.com and click on - Participant Forms.

I hereby affirm that, to the best of my knowledge, all expenses listed above are eligible for reimbursement under Section 105(h) or 129 of the IRS Code and in accordance with my contract with First Financial Administrators, Inc. I further certify that these expenses have not been, nor will not be reimbursed under any other health plan coverage. If you need verification of the eligibility of an expense, please contact First Financial Administrators, Inc. at 1-866-853-3539.

Signature: _____

Date: _____

Please send me additional envelopes (additional voucher given with every reimbursement)

NOTE: If you have direct deposit, First Financial Administrators, Inc. will not pay bank charges for insufficient funds. Please call your financial institution to verify deposit before writing any checks on the amount.

SEE BACK PAGE FOR ADDITIONAL ITEMIZATION & HELPFUL FILING TIPS

REIMBURSEMENT ITEMIZATION CONTINUED

Date of Service	Family Member	Description of Expense	Amount
Sub-total this page:			

VOUCHER INSTRUCTIONS
 Reimbursement checks will not be issued for a new plan year until we receive the first contribution from your employer!

DAYCARE SUBMISSION GUIDELINES:

Acceptable Documentation to accompany the reimbursement voucher:

1. Vouchers for Dependent Care signed by the Provider . Voucher must also be completed with the Provider' s tax identification number or Social Security number and dates of service. **or**
2. Voucher with receipt from Provider, including Provider name, Provider signature, dates of service, amount for service and tax identification / social security number.

I.R.S. Regulations prevent us from reimbursing dependent care yearly contracts. Monthly submissions are required.

UNREIMBURSED MEDICAL SUBMISSION GUIDELINES:

Acceptable Documentation to accompany the reimbursement voucher:

1. Professional bill or receipt that includes:
 - a. Provider of service
 - b. **Type of service rendered**
 - c. Original date of service
 - d. Charges for the service
2. Insurance company Explanation of Benefits
3. Pharmacy statement that includes Rx number and name of the prescription

Make sure your attached receipt(s) has detailed description of service printed on it!

Unacceptable Documentation:

1. Cancelled checks / Credit card receipts.
2. Bill or receipt that only shows a balance forward or a previous balance.
3. Cash register receipt.

NOTE: It is important to note that the date of the service, NOT THE DATE OF PAYMENT, must fall within the dates of the plan year for which you are enrolled.