Health Extras[SM] Reimbursement Form

This form should be used for services received from registered vendors only. Please fax or mail the Independent Health Reimbursement Form and itemized receipt to:

> Independent Health
> Attn: FSA Administration
> P.O. Box 9066
> Buffalo, NY 14231
> Fax (716) 774-8092

Independent Health Use Only
Ref # ____________
D/e Date ____________
D/e By ____________
Check # ____________
Paid on ____________

Please enclose copies of paid itemized receipts. All paid receipts require the date of service, description of services rendered, member receiving service and name of individual or organization providing service. Cancelled checks are not acceptable in lieu of a paid receipt.

Section 1 – Information

Name of Member Receiving Service ____________________

Independent Health ID Number *(refer to member ID card)* ____________________

Phone Number (   ) ____________________

Section 2 – Information

Dates of Services ____________________

Name of Individual or Organization Providing Service ____________________

Address of Individual or Organization Providing Service ____________________

Type of Service Received ____________________

Total Amount of Request *(receipt must be attached)* $ ____________________

Section 3 – Subscriber Signature

To the best of my knowledge and belief, my statements in this reimbursement form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible members. I certify these expenses have not been previously reimbursed in this or any other benefit year. I authorize my Independent Health Health Extra's card to be reduced by the amount requested.

Subscriber's Signature ____________________ Date ____________________

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