BASIC FLEX CARD
REIMBURSEMENT/VERIFICATION FORM

Company Name: **Davison Community Schools**

Social Security #: | | | – | | – | | | | Phone: | | | – | | | – | | | |

Employee Last Name: ____________   First Name: ____________

☐ My NEW address is:______________________________

MEDICAL EXPENSE CLAIMS

- Documentation for each request must show date of service, description of service provided and charge for service.
- **"See Attached" <u>will not</u> be accepted, you MUST itemize your expenses or your claim will be returned. Attaching an additional form is acceptable.**
- **MAIL or FAX claims to BASIC at: 9246 Portage Industrial Dr., Portage, MI 49024**
  Fax: 269-327-0716 or 800-391-6562 For questions Call: 269-327-1922 or 800-444-1922 x 1

Expenses paid using FlexCard	*Dates of Service*	*Name of Provider*	*Description of Service*				*Claim Amount*
			Medical	Rx	Dental	Vision	
❒ Yes ❒ No							
❒ Yes ❒ No							
❒ Yes ❒ No							
❒ Yes ❒ No							
❒ Yes ❒ No							
						Total to be reimbursed	$

DEPENDENT/CHILD EXPENSES

Expenses paid using FlexCard	*Dates of Service*	*Name of Provider*	*Provider TIN/SSN*	*Claim Amount*
❒ Yes ❒ No				
❒ Yes ❒ No				
❒ Yes ❒ No				
❒ Yes ❒ No				
			Total to be reimbursed	$

*Signature of Care Provider ______________________ Date:__________

I verify that the above information is true and correct and that the expenses claimed above are eligible expenses under the plan.
*If you DO NOT have a receipt your claim will not be reimbursed unless your daycare provider has signed this form.

I certify that the statement and information on this reimbursement form are accurate and true. I also certify that I am claiming reimbursement for only eligible expenses incurred during the plan year and only for eligible plan participants. I certify that these expenses have not been or will not be reimbursed under this or any other benefit plan. I further certify I will not claim these, or any other expenses reimbursed through this plan, as an income tax deduction and I assume all liability for taxes and penalties out of any disallowed deduction/credit.

*******Employee Signature:** ______________________ Date: ______________