EBSO
Expert Benefit Solutions

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Fax: 419-423-5834
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FLEXIBLE SPENDING CLAIM FORM

Please Print

Employer_____

Your Name_____

Member ID # &/or Birthdate_____ Primary E-mail Address _____

☐ My address has changed. My new address is_____

Medical/Dental Expenses

Medical/Dental expenses covered under an insurance plan must be submitted to the insurance carrier first.

****You should NOT use this form to submit documentation to substantiate expenses charged under your flex benefits debit card**. For expenses charged under the flex benefits debit card, simply attach the documentation substantiating the charges to the letter you may receive either in the mail or from ***customerservice@ebsobenefits.LH1OD.com***. It is possible that you may not have to submit documentation for some types of expenses charged under the flex benefits debit card.

In order to process your claim we must receive proper documentation. To process your expense(s) we must receive receipts, billing statements, explanation of benefits, or letters of benefit denial. They must be itemized and include the incurred dates of service. **Balance due statements and canceled checks are not acceptable.**

This entire form must be completed in order for us to process your claim. Please check the appropriate box, complete the rest of the form and send to: EBSO, Inc. at the address shown above.

___ ***The charges I am submitting have already been processed by my insurance carrier. ATTACHED SECURELY ARE: My Explanation of Benefits, letters of benefit denial, or receipts for co-payments.***

___ ***I certify that the charges I am submitting are not covered under any insurance plan or policy. ATTACHED SECURELY ARE: Itemized bills for those charges NOT covered by any other plan.***

Date of Service	Person Receiving Service (Self, Spouse, Dependent)	Type of Expense (Check One)				Total Expenses	Amount Paid By Insurance	Amount To Be Paid From Your Flex Account
		Vision	Medical	Drugs	Dental			
					Totals	$		$

I hereby certify that the information shown above is true and correct, and that neither I, my spouse, nor any of my eligible dependents have or will receive reimbursement for any of the expenses listed above from any other source, and furthermore, that I have not, and will not, claim any of these expenses as a deduction on, or in calculating a credit for, my/my spouse's income taxes. In addition, I certify that the "Person Receiving Service" listed above is eligible to be covered under the Plan.

Signature_____ Date_____

Please send completed and signed copy to customerservice@ebsobenefits.com or to the fax number or mailing address at the top of this form. Questions, contact EBSO, Inc., Customer Service at 651-695-2500 or 800-486-7664.

Rev. 09/24/2013