Claim Form

Febco Benefits Administration

Participant Information

Employer Name: ____

Employee Name: ______________________ Email Address: ______________________

Social Security Number: ______________________ Birthday: ______________________

Street Address: ____

City: ______________________ State: ______________ Zip: ______________

In order to prevent delays in claim processing, please make sure all areas are completed and supporting documentations are included. Please be aware that CANCELLED CHECKS or CREDIT CARD Receipt will not substantiate an expense being incurred, only that a payment was made. Claim must be at least $20.00 to process. **DO NOT SEND ORIGINAL RECEIPTS.**

Claim Information

RECEIPT/EOB #1

Benefit Account: ______________ Patient's Name: ______________________

Amount of Charge: $ ______________ *Dates of Service: ______________ to ______________

Merchant/Doctors Name: ______________________ *Deduct from Previous Plan Year: ☐

Description of Service: ____

RECEIPT/EOB #2

Benefit Account: ______________ Patient's Name: ______________________

Amount of Charge: $ ______________ *Dates of Service: ______________ to ______________

Merchant/Doctors Name: ______________________ *Deduct from Previous Plan Year: ☐

Description of Service: ____

RECEIPT/EOB #3

Benefit Account: ______________ Patient's Name: ______________________

Amount of Charge: $ ______________ *Dates of Service: ______________ to ______________

Merchant/Doctors Name: ______________________ *Deduct from Previous Plan Year: ☐

Description of Service: ____

Signature *(Incomplete forms will not be processed)*

Total | **$**

Your claim will be processed based on the date claim is received. Please confirm with your financial institution that funds are available before using. Febco will not pay overdraft fees. Febco cannot guarantee delivery of checks received thru the mail, there is a $30.00 cancels and reissue fee charged by the bank for all lost checks. Should you not receive your reimbursement, please contact our office immediately at (800)489-1539.

To the best of my knowledge and belief, my statements in this reimbursement request are complete and true. Furthermore, I certify that these expenses have not been previously reimbursed on this or any other benefit plan, and will not be claimed as an income tax deduction. I authorize FEBCO, Inc. to reduce my flexible spending account by the amount requested.

Employee Signature: ______________________________________ Date: ______________

Employee Name: ____

Claim Information (Continued)

RECEIPT/EOB #4

Benefit Account: ______________ Patient's Name: ____

Amount of Charge: $ _________________ *Dates of Service: ____________________ to ____________________

Merchant/Doctors Name: ____ *Deduct from Previous Plan Year: ☐

Description of Service: ____

RECEIPT/EOB #5

Benefit Account: ______________ Patient's Name: ____

Amount of Charge: $ _________________ *Dates of Service: ____________________ to ____________________

Merchant/Doctors Name: ____ *Deduct from Previous Plan Year: ☐

Description of Service: ____

RECEIPT/EOB #6

Benefit Account: ______________ Patient's Name: ____

Amount of Charge: $ _________________ *Dates of Service: ____________________ to ____________________

Merchant/Doctors Name: ____ *Deduct from Previous Plan Year: ☐

Description of Service: ____

RECEIPT/EOB #7

Benefit Account: ______________ Patient's Name: ____

Amount of Charge: $ _________________ *Dates of Service: ____________________ to ____________________

Merchant/Doctors Name: ____ *Deduct from Previous Plan Year: ☐

Description of Service: ____

RECEIPT/EOB #8

Benefit Account: ______________ Patient's Name: ____

Amount of Charge: $ _________________ *Dates of Service: ____________________ to ____________________

Merchant/Doctors Name: ____ *Deduct from Previous Plan Year: ☐

Description of Service: ____

RECEIPT/EOB #9

Benefit Account: ______________ Patient's Name: ____

Amount of Charge: $ _________________ *Dates of Service: ____________________ to ____________________

Merchant/Doctors Name: ____ *Deduct from Previous Plan Year: ☐

Description of Service: ____

Total $

Please fax this form to: 502-695-9692

www.febco.com

Febco Benefits Administration
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Frankfort, KY 40602