



MISSOULA COUNTY EMPLOYEE BENEFITS PLAN

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FLEX MEDICAL EXPENSE REIMBURSEMENT REQUEST

Use this form to submit a Flex Reimbursement Request for eligible medical expenses. This includes out-of-pocket costs for Medical, Dental, Vision, Pharmacy and certain over-the-counter items. Please complete all fields below and include the appropriate supporting documentation. If the required documentation is not attached with this form, your reimbursement will be denied and returned to you.

- **Medical, Dental, Vision expenses**– copy of Explanation of Benefits (EOB)
- **Prescription expenses**– Pharmacy receipt showing Rx information and Patient Responsibility
- **Over-the-Counter expenses**– Detailed receipt (please note certain items require letter of medical necessity or prescription from your provider.)

Plan Year:

Department:

Daytime Phone#:

Employee Name:

SSN:

Employee Address:

Direct deposit is available and encouraged. Please reach out to MCEBP if you would like to have reimbursements directly deposited into your bank account. If a paper check is issued, it will be mailed to the address on file.

Date(s) Incurred	Name of Provider, or Description of Service(s) Rendered	Covered by insurance?	Out-of-Pocket Medical Expense(s)
		Yes ☐ No ☐	
		Yes ☐ No ☐	
		Yes ☐ No ☐	
		Yes ☐ No ☐	
		Total Medical Expenses (Minimum \$10)	\$

I certify to the best of my knowledge, the statements made within this Request for Reimbursement are complete and true. I certify the medical expenses were necessary to treat a medical condition for myself, my tax dependents, and/or spouse. I further understand that expenses reimbursed by Flex may not be claimed on my income tax return as an income tax reduction. I authorize my Flexible Spending Account to be reduced by the amount requested.

Signature

Date

For additional forms, go to www.mcebp.com