If Faxing # of Pages:

myCafeteriaPlan Medical Reimbursement Claim Form

myCAFETERIAPLAN.com
YOUR SECTION 125 PLAN SERVICE SPECIALISTS

EMPLOYEE INFORMATION *(Please Print)*

☐ Check here if address has changed

Name: _____ SSN: _____

Address: _____ Day Phone _____

City, State, Zip: _____ Employer: _____

UNREIMBURSED MEDICAL EXPENSES *(Attach supporting documentation)*

Does your receipt include all of the following?

☐ Provider's name and address ☐ Patient's name
☐ Service description ☐ Amount billed
☐ Date of service

***** Credit card receipts are not acceptable *****

Person for Whom Expense was Incurred	Date(s) of Service	Name of Service Provider	Description of Services	Amount
		Total Unreimbursed Medical Expenses		$0.00

READ CAREFULLY

The above is a true and accurate statement of all expenses incurred by my eligible dependents or me on the date(s) indicated, and were incurred while I was covered under the Flexible Spending Account(s). Supporting documentation from my service provider(s) for all expenses are attached to this voucher. I understand that I cannot claim any reimbursed expenses on my income tax return, and that I may be liable for payment of all related taxes including Federal, State, or City income tax and any associated penalties on the amounts paid for any expense improperly claimed under the provisions of the Flexible Spending Account(s).

_____ _____

Participant Signature Date

Mail To: myCafeteriaPlan, 432 East Pearl St., Miamisburg, OH 45342
Fax To: 937.865.6502 **Email To**: claims@myCafeteriaPlan.com

To contact Customer Service, call 800.865.6543

Access your account information 24 hours a day, seven days a week on our web site: www.myCafeteriaPlan.com