



**BlueCross BlueShield
of Alabama**

An Independent Licensee of the Blue Cross and Blue Shield Association.

Request For Reimbursement Preferred Health FSA

Attach a copy of the itemized bill and a Claim Processed Report (if applicable) along with proof of payment. All documentation must include the patient name, description of service provided, date provided, and the charge. Be sure to sign and date this form before sending it with all attachments to the address shown.

**Blue Cross and Blue Shield of Alabama
Benefits Service Center
P.O. Box 11586
Birmingham, Alabama 35202-1586
1 800 213-7930**

Toll Free Fax 1 877 889-3610 • Birmingham Area Fax 1 205 220-7991

Visit our web site www.bcbsal.com for detailed account information

EMPLOYEE INFORMATION				PREFERRED BLUE ACCOUNT NUMBER	
Employee Name (Please Print)	Last	First	MI	Your Preferred Blue Account number is your Blue Cross and Blue Shield of Alabama contract number. If you do not have your account number, please contact Customer Service.	
Company Name				Work Telephone (Please include Area Code)	Home Telephone (Please include Area Code)

HEALTH FSA REIMBURSEMENT INFORMATION

In order to be properly reimbursed, please complete this section for each eligible receipt. (Please attach all necessary receipts.)

Name	Relationship	Date of Birth	Date of Service	Amount
1.	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent*	MM / DD / YYYY	MM / DD / YYYY	
2.	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent*	MM / DD / YYYY	MM / DD / YYYY	
3.	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent*	MM / DD / YYYY	MM / DD / YYYY	
4.	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent*	MM / DD / YYYY	MM / DD / YYYY	
5.	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent*	MM / DD / YYYY	MM / DD / YYYY	
6.	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent*	MM / DD / YYYY	MM / DD / YYYY	
			TOTAL	\$

*I certify that the attached expenses are eligible for reimbursement from my designated Health FSA and that they qualify as deductions as outlined by the Internal Revenue Code. I request reimbursement up to the limit allowed based on my election. I further certify that these expenses have not been reimbursed and are not reimbursable under any other benefit plan. * Dependent must be considered an eligible dependent under the applicable provisions of the Internal Revenue Code.*

SIGNATURE OF EMPLOYEE

DATE SIGNED

Important: This form is not used to reimburse you for your Blue Cross and Blue Shield of Alabama health benefits. It may only be used to request a payment from a tax-deferred, employee-funded spending account established by your employer under Section 125 of the U.S. Internal Revenue Code. Payments from such an account may only be made for qualified expenses on behalf of qualified dependents when such expenses have not been reimbursed and are not reimbursable by any other benefit plan.