

# Medical Savings Account Request for Reimbursement

Please complete the applicable spaces on this form, and attach appropriate paid bills or receipts before submitting for reimbursement. Specific service and dates must be provided for all health reimbursement claims. All claims submissions must also reflect insurance reimbursement.

Employee Name: \_\_\_\_\_ Soc. Sec. Num: \_\_\_\_\_

Home Address: \_\_\_\_\_

Phone (Work): \_\_\_\_\_ Phone (Home): \_\_\_\_\_

	<i>Type of Expense*</i>	<i>Date Incurred</i>	<i>Provider/Doctor/Pharmacy/etc.</i>	<i>Amount</i>
1.	_____	_____	_____	\$ _____
2.	_____	_____	_____	\$ _____
3.	_____	_____	_____	\$ _____
4.	_____	_____	_____	\$ _____
5.	_____	_____	_____	\$ _____
6.	_____	_____	_____	\$ _____
7.	_____	_____	_____	\$ _____
8.	_____	_____	_____	\$ _____
<b>TOTAL</b>				\$ _____

\* Types of Expenses: M=Medical, D=Dental, V=Vision, H=Hearing, O=Orthodontics, PD=Prescription Drugs, OT=Other

To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not be claimed as an income deduction. I authorize my health care medical savings account be reduced by the amount requested.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SEND CLAIMS TO: Abel Business Services, Inc.  
540 West Boston Post Rd.  
Mamaroneck, NY 10543-3437**

**Phone: (914) 777-1041  
Fax: (914) 777-1098**

## **STEPS TO RECEIVE REIMBURSEMENT:**

1. Only submit expenses **incurred** in the current Plan Year.
2. Receipts must be only for yourself or your eligible dependents.
3. With all requests for reimbursement you **must** provide:
  - date the expense was **incurred** (actual date of service)
  - description of expense
  - amount submitted for reimbursement
  - an Explanation of Benefits (EOB) or receipt from the provider showing proof of amount paid and date of service.
4. The reimbursement form must be completed, signed and dated or it will be returned for the missing information.

**\*\*No reimbursement will be made without all necessary information.\*\***

Reimbursement requests may be sent directly to Abel Business Services, Inc. at the following address:

**Abel Business Services, Inc.  
Attn: MSA Reimbursements  
540 West Boston Post Rd.  
Mamaroneck, NY 10543-3437**

Medical care reimbursement dollars are paid subject to a \$25 minimum, except at the end of the plan year when any remaining dollars due to you will be paid for any outstanding bills. Federal law requires that any unused account balance(s) remaining after the end of the plan year be forfeited. Claims incurred during a Plan Year may be filed up to March 31 of the following year.