



**ICUBA – NOVA SOUTHEASTERN UNIVERSITY  
MEDICAL AND DEPENDENT CARE EXPENSE ACCOUNT  
REIMBURSEMENT REQUEST FORM**

Name	SS#		<b>Mail or fax claims to:</b> OutsourceOne P.O. Box 616927 Orlando, FL 32861-6927 Toll-free phone: 866-377-5102 Ext. 23 Toll-free fax: 866-377-5180
Home Address	Address Change	Yes No	
City	State	Zip	
Phone: Work Home	e-mail		

Complete the information below for expenses incurred by you, your spouse, or dependent children for which you request reimbursement. You must provide receipts or other evidence the expenses were incurred. Be sure to provide all information requested on this form. If the form is incomplete it will be returned to you. Print or type the information requested, then sign and date the form. Mail or fax this form and supporting documentation to OutsourceOne.

FSA MEDICAL EXPENSES (Medical, Dental, Vision)					
	Provider of Service (Doctor, dentist, pharmacy, etc.)	Person Receiving Service (self, spouse, child)	Dates of Service (MO/DAY/YR)	Amount of Expense Claimed	Nature of Expense
1				\$	
2				\$	
3				\$	
4				\$	

DCRA DEPENDENT CARE EXPENSES (if necessary, attach additional sheets)						
	Provider of Service	Person Receiving Service (Dependent's name)	Age of Dependent	Dates of Service (MO/DAY/YR)	Amount of Expense Claimed	Provider Tax I.D. Number (Social Security Number if Individual)
1					\$	
2					\$	
3					\$	

**Dependent Care Provider's Signature (if individual)** \_\_\_\_\_

I request payment from my health care expense or dependent day care expense account as indicated above for the expenses listed. To the best of my knowledge and belief, my statements in this reimbursement request are complete and true. I am claiming reimbursement only for eligible expenses incurred during the plan year and for my eligible dependents. I certify that these expenses have not and will not be reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I authorize my Flexible Spending Account to reimburse me by the amount requested.

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

PLEASE SEE REVERSE SIDE FOR FILING INSTRUCTIONS

