



BlueSaverSM FSA
Medical Reimbursement Request
Please print all information

Employee information

Group name _____

Employee name _____ Social Security number _____

Address _____

City _____ State _____ Zip code _____

Work phone (_____) _____ Home phone (_____) _____

E-mail address _____

To process your request, Independence Blue Cross must receive the following items with this completed, signed form:

- Copy of the Explanation of Benefits (EOB) you received from your (or your spouse's and/or dependent's) health, dental, vision, or prescription drug plan; OR
- Copies of the provider's itemized bills showing the provider's name, dates the provider performed the services, patient's name, description of the services, and the total charge. You may omit bills if the EOB includes all of this information.

Reimbursement request(s)

Patient's first and last name	Relationship to employee	Provider's name	Date(s) of service	Amount requested

Employee certification: I certify that I or my eligible dependent, as declared on my personal income tax return, incurred these charges. I have not been reimbursed, and am not eligible to be reimbursed, by any other source. I understand that I cannot claim any of the reimbursed expenses shown on this form as a deduction on my federal income tax return.

Employee signature: _____ **Date:** ____/____/____

Mail completed form with the appropriate attachments to
Independence Blue Cross
c/o BlueSaver FSA Administrator
P.O. Box 1004 • Horsham, PA 19044
(866) 866-4695

Independent Licensee of the Blue Cross and Blue Shield Association.
 FSA benefits are administered by AmeriHealth Administrators, Inc.