Innovative Business Consultants

Reimbursement Request Form

FSA _____ HRA _____

Employer Name	Employee Email Address

Employee Name	Employee Phone #

Employee Address

City	State	Zip

Health Care Expenses

Date of Service	Patient Name	Relationship to Employee	Provider Name (Dr/Pharmacy	Total Charge	Amount to be Reim-bursed

***Attach an Explanation of Benefits (EOB), an itemized receipt, or 3rd party verification of each expense claims, indicating services provided, dates of service and charges. Balance forward statements, cancelled checks & credit card receipts are NOT acceptable documentation for reimbursement.**

You can also file reimbursement claims online through the Consumer Portal at:
https://ibcmember.LH1ondemand.com

I hereby request payment from my flexible spending account for the expenses listed above. I certify that I have not been reim-bursed for the expenses from any other health plan. I understand that any expenses reimbursed may not be used to claim on federal income tax deduction or credit. I hereby authorized deduction from my flexible spending account.

____ _______________
Employee Signature Date

****FAX COMPLETED FORM & SUPPORTING DOCUMENTS TO (712) 277-2622 or email claims@ibcins.biz. Retain**