Innovative Business Consultants

Reimbursement Request Form

FSA _____ HRA _____

Employer Name	Employee Email Address	
Employee Name	Employee Phone #	
Employee Address		
City	State	Zip

Health Care Reimbursement Information

Date of Service	Patient Name	Relationship to Employee	Provider Name (Dr/Pharmacy)	Total Charge	Amount to be Reimbursed

The IRS requires you to substantiate all claims with documentation. The documentation must detail the healthcare expenses and include these five requirements:

1. Name of provider
2. Name of patient
3. Description of services
4. Date(s) of service. The paid date may or may not be the same as the date of service; the date of service is required.
5. The cost of the service

Balance forward statements, cancelled checks & credit card receipts are NOT acceptable documentation for reimbursement

I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible expenses incurred by myself or an eligible dependent while I was a participant in the plan. (Patient & Relationship is assumed to be Self unless otherwise indicated.) I have already received these products and services and confirm that by requesting reimbursement here that I have not and will not seek reimbursement of this expense from any other plan or party .

Employee Signature: _____ Date: _____

Fax completed form & supporting documents to (712) 277-2622 or email claims@ibcins.biz.
You can file claim reimbursements online through the Consumer Portal at https://ibcmember.LH1ondemand.com
Retain original documents for your records

412 Water Street | Sioux City | IA | 51103
Phone (712) 277-2424