MEDICAL REIMBURSEMENT VOUCHER

Employer: Rhodes College Soc. Sec. #____

Employee Name: ____

To: Flexible Spending Department

The undersigned participant in the Plan requests reimbursement in the amounts shown below. (Attach proof of amount owed showing dates of service in the form of itemized bills, receipts, and invoices for all expenses claimed). If expense is incurred by my dependent, such dependent qualifies as a deduction on my federal tax return.

MEDICAL CARE EXPENSE

Date Incurred	Name of Service Provider	Describe Expense	Patient Name	Date of Birth	Amount Claimed

Total expenses claimed $ ____________

Read carefully

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim, and that the undersigned may be liable for payment of all related taxes including federal income tax on amounts paid from the Plan which relate to such expense.

Signed: ____ Date: ________________

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