



Flexible Benefits Plan



Medical Reimbursement Voucher Form

EMPLOYER NAME: RESEARCH FOUNDATION FOR MENTAL HYGIENE, INC.

GROUP: 1885

EMPLOYEE NAME: _____ **SOCIAL SECURITY NO.** _____

EMPLOYEE ADDRESS: _____ (_____) _____
Number/Street City State Zip Daytime Phone Number

Email: _____ Yes, I want to receive my Quarterly Statements and other communications by email

Please check if this is a new address.

For CFH use only

Instructions:

- Each expense **must** be itemized on this form and substantiated by a written statement from the provider of the qualifying product or service certifying:
 - The date the product or service was provided
 - A description of the product or service provided
 - The amount charged
 - The name of the provider
 - The name of the person to whom it was provided
- Canceled checks will not be accepted for claim substantiation.** Attach bills, receipts, insurance benefit determinations, and/or attending physician statements.
- Please be sure to sign and date this form.
- Please make a photocopy of the reimbursement voucher form and documentation for your records. Your completed Reimbursement Voucher Form and supporting documents must be submitted to the following address, to ensure prompt reimbursement:

Flex Claims
Charles F. Herman & Associates, Inc.
PO Box 13565
Albany, NY 12212-3565

Important:
Your claim will be returned unless all of the listed elements are clearly identified on your receipt.

I am claiming the following Medical expenses:				
OTC Code*	Date of Service	For the Benefit of: (Name and Relationship)	Description of Service	Amount
MEDICAL EXPENSE TOTAL				\$

* OTC Codes Required – The number or letter corresponding to the OTC Item must be recorded in the OTC Code column

- A. Small quantities, of the following items, do not require a physician's letter to be reimbursed by the plan**
- Allergy Medicine or Cold & Flu Medicine, containing analgesic, antihistamine or antitussive formulation
 - Antibacterial cream
 - Balm for treating muscle and joint pain
 - Burn cream or ointment containing antibiotic
 - Diaper rash ointment
 - Foot preparations containing antifungal
 - Gastrointestinal medicine containing antacid, antifatulent, antidiarrheal, antiemetic, laxative or fecal softener
 - Hemorrhoid treatment, including suppositories and creams
 - Insect bite medication containing Anti-Infective agent
 - Nicotine gum or patches for stop-smoking purposes
 - Ophthalmic preparation
 - Pedialyte or similar formulation for treating an ill child
 - Pain reliever containing aspirin, ibuprofen or acetaminophen
 - Respiratory product containing sympathomimetic

- Sinus medicine or nasal sinus spray
- Wart removal medication

Reimbursement for the following items is permitted only if your claim is accompanied by a letter from a licensed physician recommending the use of these items for (1) the treatment of a specific medical condition, not for general health and (2) for a specified time duration. The letter must specify the condition being treated and the duration of the treatment program.

- Fiber supplements and digestive aids
- Herbal medicines and vitamins
- Hormone therapy to treat symptoms of menopause
- Prenatal vitamins
- Sedatives and Hypnotics
- Weight-loss drugs used to treat a specific disease (including obesity). Items that replace normal food consumption are not reimbursable.

Certification

The expenses listed on this form are eligible under the Flexible Benefits Plan. I certify that I have incurred these expenses on behalf of myself or my eligible dependent(s). I will not seek reimbursement from my insurance carrier or any other source and I will not claim these expenses as a deduction or for a credit when filing Internal Revenue Service Form 1040.

Employee Signature: X _____

Date: _____