q3 business technology corp.
P. O. Box 15952
Fort Wayne, IN 46885

www.q3online.com
Phone 260.492.9979 877.251.8324
Fax 260.492.9989

Medical Spending Account
Reimbursement Claim Form

Note: Every item must be completed before claim can be processed! (please print in ink or type)

Employer/Plan Name: ________________________________

Enrollee Name: ________________________________ ID #: _____________

Address: ________________________________

City/State/Zip: ________________________________

Instructions

1. For medical/dental expense claims that were submitted to a medical plan or an insurance company but not paid by that carrier, attach copies of other insurance carrier claim and/or payment forms (explanation of benefits forms) to establish amounts not covered under the plan.

2. For all other reimbursable expenses, copies of all bills must be attached which show who (name and address) rendered the service, reason for charge and date and amount of charge. Canceled checks are not acceptable receipts. Beginning 1/1/2011, by law, items which may be purchased without a prescription are not reimbursable unless prescribed by a doctor (please attach a copy of the prescription).

3. Submit this form to q3 at the address above. Retain a copy for your records.

Expenses

Expenses (list below) Item	Date Expense Paid	Reason for Payment**	Amount Paid
1.	______________________	_______________________	____________
2.	______________________	_______________________	____________
3.	______________________	_______________________	____________
4.	______________________	_______________________	____________

**Use the following letter designation for "Reason for Payment":

A. medical/dental expense submitted to insurance company but not paid by the carrier (for example; a co-insurance, copayment or deductible amount);
B. medical/dental expense not covered by a benefit plan;
C. optical expenses.

Employee Certification

I certify that all items requested to be reimbursed comply with the Flexible Spending Account Plan and such items have not and will not be covered by any other plan or program of any employer or other person. I further certify that such items will not deducted or taken as tax credits on my personal federal and state income tax returns for any year. I understand this plan does not accept responsibility for direct payment to any individuals other than the employee.

____________________________________ ____________
Employee Signature Date