



# BestFlex Account Reimbursement Form

**Instructions:**

1. Copies of bills indicating date of service, provider name, patient name, and charges must be enclosed with the reimbursement form unless you are submitting an Explanation of Benefits (EOB) statement from an insurance carrier. Reimbursement checks will be generated for amounts of \$25.00 or more.
2. All areas of the reimbursement form must be completed for any claim to be processed.
3. If you have any questions, please call BC & S Associates at (315) 448-4957.

Mail to: BC & S Associates, Inc.  
344 S. Warren Street  
P.O. Box 4982  
Syracuse, New York 13221

Employer Name \_\_\_\_\_

Social Security Number \_\_\_\_\_

Employee Name \_\_\_\_\_

Employee Phone Number (\_\_\_\_) \_\_\_\_\_

Employee Full Address \_\_\_\_\_

(Please check here if address has changed.) (Street)

(City) (State) (Zip)

TOA <small>Office Use Only</small>	Date(s) of Service	Amount	Provider of Service	Description of Service	Claimant Name	Relationship to employee <small>(Self/Spouse/Child Other - Specify)</small>	Provider TIN <small>(Tax ID#, Dependent Care only)</small>

I certify that the expenses for which reimbursement is being requested have been incurred for myself, my spouse, and/or my dependents. Any medical expenses for which I am requesting reimbursement are expenses which have not been reimbursed and are not reimbursable under any other health plan coverage. I understand that I must provide the taxpayer identification number of the dependent care provider on my federal income tax return if I am requesting reimbursement of dependent care expenses, and I will comply with this requirement. My spouse is not claiming reimbursement for the dependent care expenses under any coverage provided by his or her employer.

**All of the matters stated in this reimbursement form are true and correct to the best of my knowledge and belief.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date