

Section 125 Flexible Benefit Plan

**HEALTH CARE TRAVEL REIMBURSEMENT REQUEST**

*"Please Print"*

Employer Name:	
Name of Employee:	SSN: (required)      -      -
Address:	Address Change: <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State/Zip:	Email Address:

***Expense Information - Please Print***

Please provide the following information for each expense for which you are requesting reimbursement. In order to be eligible for reimbursement, the transportation expense must be incurred **primarily for, and essential to, medical care**. Examples of eligible transportation expenses include: mileage, parking, and tolls, as well as, taxi, bus, or plane fares incurred in order to receive medical care. Certain restrictions apply when traveling to another city for medical care – contact a Plan representative for details. Medical mileage is paid at the current medical mileage rate allowable by the Internal Revenue Service. **Substantiation of medical service is required**. Substantiation (provider statement or invoice) must reflect: **date of service, provider name, provider location, and service rendered**. Documentation attached to this request will be used as substantiation of medical transportation expenses only – reimbursement of provider fees will not be processed from this submission. Any request for reimbursement of provider fees must be submitted separately using a Health Care Reimbursement Request form and required documentation (as described on the Health Care Reimbursement Request form).

<u>Date of Travel</u> (mm/dd/yy)	<u>Provider Name</u> (Dr., hospital, etc.)	<u>Travel From / To</u> (city / city)	<u>Expense Type</u> (mileage, parking, etc.)	<u>Expense Amount</u> (if mileage – indicate # of miles driven)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
Total Amount Requested				\$ _____
Total Number of Miles				_____ X _____ = _____

**Participant Acknowledgement:** Reimbursements will only be made for expenses incurred **prior** to the date of the Reimbursement Request. An expense is considered to be **incurred** when the service is provided not when payment is made. Reimbursements will only be made when accumulated claims exceed \$25.00. The \$25.00 requirement is waived at the end of the plan year. All payments and correspondence will be issued directly to you. I hereby certify that this information is, to the best of my knowledge, correct and that I have not or will not be reimbursed by any other plan or program nor will the expense(s) be used as basis for a tax deduction. I also certify that the expense(s) were incurred primarily for, and essential to, medical care. Claim documentation cannot be returned – please keep copies for your records.

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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