LCS MANUAL CLAIM FORM
REIMBURSEMENT REQUEST FORM

MURFEE MEADOWS, INC.
120 Office Park Drive, Suite 100 * Birmingham, AL 35223 * 205-871-9515 * (toll-free) 1-800-600-0947
Fax 205-871-9519

(Please make additional copies as needed)

INSTRUCTIONS: **Please print or type.** Complete all items under Personal Information. In order to receive reimbursement you must report the requested amount for each Health Care Claim. **Please attach receipts**. For Dependent Care reimbursement you have two choices: 1) fill-out **all** items in the *Dependent Care Expenses* section and attach a receipt of your payment, **OR** 2) fill in your dependent's name, age, date of service and the requested amount **and** have your Day Care provider complete the *Affidavit of Dependent Care Provider.* You must sign and date the form in order for us to process it. Email, mail or fax all documents to your Plan Administrator at Murfee Meadows, Inc. at the address listed above.

PERSONAL INFORMATION

Employer's Name **LEON COUNTY SCHOOLS**	
Employee's Name	Date of Request
SSN	Daytime Phone No.

UNREIMBURSED HEALTH CARE EXPENSES

Unreimbursed Medical, Dental, Over-The-Counter Items, etc.
(Attach all receipts)

Total: $_____

DEPENDENT CARE/CHILD CARE EXPENSES

	Dependent's Name	Age	Date of Service		Requested Amount
			From	To	
1					
2					

Provider's Name — **Total: $**_____

Provider's Address

Provider's Tax ID or Social Security Number

AFFIDAVIT OF DEPENDENT CARE PROVIDER

I have provided adult/child care for _____ age _____ for the period beginning _____ and ending _____. Services were provided by _____ for a fee of $ _____.

Signature of Provider _____ Tax ID# of SS# _____ Date _____

I, the undersigned, hereby certify that the above listed expenses have not been previously reimbursed from my Flexible Spending Account, nor are they reimbursable from any other source. I hereby authorize Murfee Meadows, Inc. to obtain necessary information from all physicians, hospitals, day care providers, employers and all other agents in order to adjudicate the claim for reimbursement under the Benefit Plan established by my employer.

Employee Signature _____ Date _____