



Please type or print all information

COMPANY NAME:

ONLY USE THIS FORM IF YOU HAVE ONE OF THESE CARDS

Social Security Number: (for security purposes please provide at least the last 4 digits of you ss#)

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Employee Last Name:

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Employee First Name:

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MEDICAL EXPENSES

- Documentation for each request will need to show date of service, description of service provided and charge for service as well as the providers name and address.
- Please itemize your expenses to help assure proper processing. If you have more expenses than this form allows please attach a separate form. If you do not itemize your expenses we will process your claim based on the documentation received
- Mail claims to: 9246 Portage Industrial Dr, Portage MI 49024; Fax: 800-391-6562 or Email to claims@basiconline.com
- For questions call 800-444-1922 ext 1 or 269-327-1922 ext 1

Flex debit card used for this expense	Date of service	Provider name or name of store	Amount
YES NO			
YES NO			
YES NO			
YES NO			
YES NO			
YES NO			

DAY CARE EXPENSES (dependent care account)

- Please have your day care provider sign this form on the line below or provide a receipt for the services

Flex debit card used for this expense	Dates of service	Day care provider name	Amount
YES NO			
YES NO			
YES NO			
YES NO			

SIGNATURE OF DAY CARE PROVIDER: