EBS Benefit Solutions
An Excellus Company

# St. Lawrence University
## Flexible Spending Account
## Reimbursement Request Form

Employer Name

Participant First Name | MI | Last Name

Address

City | State | Zip Code

Email Address

University ID # (S L)

Phone Number

| Claimant Name | Date of Service | Amount | Type of Service | Claim Ref # | EBS Use Only |
|---|---|---|---|---|---|
| | | | ❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx | 01 | |
| | | | ❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx | 02 | |
| | | | ❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx | 03 | |
| | | | ❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx | 04 | |
| | | | ❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx | 05 | |
| | | | ❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx | 06 | |
| | | | ❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx | 07 | |
| | | | ❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx | 08 | |

- For each claim, attach Explanation of Benefits (EOB), or itemized bill showing: date of service, provider name, patient name, charged amount and description. For Dependent Care, include the provider's tax id or SSN. **Do not send credit card receipts or cancelled checks.**
- Please be sure to provide your 7 digit University ID number.
- Mail to EBS Benefit Solutions, FSA Dept, PO Box 22999 Rochester, NY 14692.
- For faster reimbursement processing, submit your claims online at www.myebsaccount.com.
- If covered by insurance, submit EOB or bill showing insurance payment.
- Submit one expense (either product or service) per row, even if items are contained on the same receipt. Each item must be itemized and must have a corresponding receipt. Label receipts to correspond to "Claim Ref #". If you have more than 8 items to submit, use additional Reimbursement Request Forms. *Note: Please do not "lump" or group items together or write "see attached". EBS can only process claims that are properly submitted. Claims will be returned to you unless they are properly submitted.*
- Call Customer Service with questions at 800-327-7130.

By submitting this form to EBS, I certify that the information here is true and correct, that the expenses incurred were for myself, spouse or qualified dependents and that these expenses are not reimbursable under any other plan coverage.