412 Water Street, Sioux City, IA 51103
Phone: 712-277-2424/800-763-1897
Fax: 712-277-2622
www.ibcins.biz

REIMBURSEMENT REQUEST

FSA___ HRA___

Employer Name	Employee Email Address	
Employee Name	Employee Phone #	
Employee Address		☐ New Address
City	State	Zip

Health Care Expenses

Patient Name	Relationship to Employee	Provider Name (Dr/pharmacy)	Date of Service	Total Charge	Amount to be Reimbursed

Attach an Explanation of Benefits (EOB), an itemized receipt, or 3rd party verification of each expense claims, indicating services provided, dates of service and charges. Balance forward statements, cancelled checks & credit card receipts are NOT acceptable documentation for reimbursement.

You can also file reimbursement claims online through the Consumer Portal at:
https://ibcmember.lh1ondemand.com

I hereby request payment from my flexible spending account for the expenses listed above. I certify that I have not been reimbursed for the expenses from any other health plan. I understand that any expenses reimbursed may not be used to claim on federal income tax deduction or credit. I hereby authorize deduction from my flexible spending account.

Employee Signature:_____ Date: _____

FAX COMPLETED FORM & SUPPORTING DOCUMENTS TO (712) 277-2622 or email claims@ibcins.biz. Retain original documents for your records.