LMT Reimbursement Request

Advanced Benefit Strategies
Your Flexible Benefits Specialists

IRS Section 125
LIMITED Health Care Reimbursement (LMT) Account

I. Employee Information

Your Employer	Your Name
( ) Day time telephone number	Social Security Number

Documentation must be attached to verify all submissions and must include the dates of services. Cancelled checks and credit card receipts are not sufficient forms of receipt. Acceptable forms of documentation are:

- Itemized Statement from your dentist or vision provider
- Copy of Explanation-of-Benefits from your insurance company showing that the charges were not covered

II. Limited Health Care Reimbursement Submissions

Dates of Service	**Type: Vision, Dental Only** (All eligible healthcare claims after medical deductible is met)	Cost
		$
		$
		$
		$
		$
		$
		$
	TOTAL:	$

III. Certification

I certify that the reimbursement requests are for expenses incurred for my spouse, eligible dependent or myself. I will not receive payment from any other source and that these are qualified expenses. I am responsible for determining my eligibility for submitting these claims, ensuring that these claims are within the limits set forth in your High Deductible Health Plan and your Heath Savings Account in conjunction with a Limited Health Care Reimbursement Account.

Signature: _____ **Date:** _____

Mail claims to: Advanced Benefit Strategies, 30 Mill Street, Unionville, CT 06085
Fax claims to: 860-673-2207
Questions? Phone 860-675-2261 or toll free at 877-732-8125 or www.abs125.com