

# StLL Flex

StLL Flex  
Medical & Dental Reimbursement Account  
Claim Form

**Claim Form Instructions:**

- 1) Copies of bills indicating date of service, provider name, patient name, and charges must be enclosed with the claim form unless you are submitting an Explanation of Benefits (EOB) statement from an insurance carrier.  
**Reimbursement checks will be generated for amounts of \$25 or more.**
- 2) All areas of the Claim Form must be completed for any claim to be processed.
- 3) If you have any questions, please call the Claims Administration Office at (315) 287-2028, or write at:

St. Lawrence-Lewis  
Claims Administration Office  
P.O. Box 300  
Richville, NY 13681

**Fill out the following information:**

School District: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Employee Social Security Number: \_\_\_\_\_

Employee Phone Number: \_\_\_\_\_

**Employee Address:** \_\_\_\_\_

\_\_\_\_\_  
(City) (State) (Zip)

0 (Please check here if address has changed)

Office Use Only	Date(s) of Service	Amount	Provider of Service	Provider's Social Security (Babysitter) or Tax ID 0 (Day Care Centers) - Must Be Completed	Claimant Name	Relationship to Employee (i.e. Self/spouse/Child Other-must Specify)

I certify that the expenses for which reimbursement is being requested have been incurred for myself, my spouse, and/or my dependents. Any medical and/or dental expenses for which I am requesting reimbursement are expenses which have not been reimbursed and are not reimbursable under any other health plan coverage.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)