Insurance, Benefits & Consulting

Deductible Reimbursement Request Form
For Employees of ChristianFamily Care

Send the following items to the email, fax, or address below or use the app!

1) Completed Deductible Reimbursement Request Form
2) Explanation of Benefits (EOB) from BCBS of Arizona

Email: submit@fbcserv.com
Fax : 602.277.8067
Mail: FBC Insurance, Benefits & Consulting
14201 N 87th Street, Suite D141
Scottsdale, AZ 85260

SCAN ME

Online: Download app by visiting myfbcapp.com
OR Scan with your phone camera

Deductible Reimbursement for the HSA Plans: After the first $1,400 of the deductible, Christian Family Care will reimburse employees and their dependents 80% of the last $4,600 ($3,680) of the deductible **for in-network services only**.

Please help FBC process your request for reimbursement
by providing the following information:
(please print)

Submittal Date: _____ Total Pages: _____

Employee Name: _____ Daytime Phone: _____

Employee Email: _____

Request for reimbursement is made for out-of-pocket medical expenses for:

- ☐ Myself
- ☐ My Dependent (First & Last Name): _____

AUTHORIZATION & CERTIFICATION:
I authorize FBC Insurance, Benefits & Consulting to review the documentation I have provided in this transmission. I understand that this information will be used only for the purposes for which it is intended and will not be disclosed to other parties without my express permission.

I certify that I am claiming reimbursement for only eligible expenses incurred during the 2022 plan year and only for eligible plan participants.

_____ _____
Signed Date