



**AZLE INDEPENDENT SCHOOL DISTRICT  
FLEXIBLE BENEFIT ACCOUNT REIMBURSEMENT REQUEST**

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

Address: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

(List ALL dependents that this submission covers)

**FLEXIBLE BENEFIT SPENDING ACCOUNT**

Do you have insurance for these services? \_\_\_\_\_ Yes \_\_\_\_\_ No With the exception of your insurance with your Employer, are these services covered by any other Insurance (spouse's) or Medicare? \_\_\_\_\_ Yes \_\_\_\_\_ No The other insurance is with: \_\_\_\_\_

**If you wish us to pay your doctor/ dentist direct:**

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ SS # / Tax ID #: \_\_\_\_\_

**IF THIS EXPENSE IS BEING APPLIED TO YOUR DEDUCTIBLE, YOU MUST SUBMIT IT TO YOUR INSURANCE CARRIER "PRIOR" TO SUBMITTING IT TO HIGGINBOTHAM & ASSOCIATES.**

If insured please submit copies of your Insurance Explanation of Benefits. For uninsured expenses, **attach receipts that include date of service, provider, amount of charge, and explanation of expense.** Amounts covered do not include payments under any other health care plan or program, Federal State or governmental program, worker's compensation or any other policy of health insurance.

I certify that the above information is to the best of my knowledge correct and that each item of expense is eligible for reimbursement. I understand that payment by the Plan is not guarantee that these amounts will not be taxable to me. I authorize any physician, concerning health history or other insurance for me or my dependents, to furnish such records, data or information as may be requested by HIGGINBOTHAM AND ASSOCIATES.

**Signature of Employee:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PLEASE MAIL OR FAX TO:** PAM HAMLIN  
C/O HIGGINBOTHAM & ASSOCIATES  
500 W. 13<sup>TH</sup> STREET  
FT. WORTH, TX 76102

PHONE: (866) 419-3516      FAX (817) 882-9267