Flexible Spending Account Claim Form

Today's Date _____/_____/_____ # of Pages ________ Plan year beginning for _________

☐ New Claim ☐ Resubmission of Claim ☐ Response to claim denial

Employer Name/Division Name:		Employee Name:
Address: ☐ Please check if change of address		
Social Security Number:	Email Address:	Home Phone: Work Phone:

Please Note: Not all these accounts may apply to your group.

☐ **Medical Expense Reimbursement Account** **Total Amount Requested___________**

- Enclose insurance company statement or itemized bill from provider showing date of service, services rendered, provider of service, amount paid, and (if applicable) amount covered by insurance.
- Prescription claims MUST include the Rx number and pharmacy receipt, not cash register receipt.
- Allowable reimbursement for mileage expenses.

☐ **Dependent Care Reimbursement Account** **Total Amount Requested___________**

Must include provider Tax ID number.

☐ **Individual Premium Reimbursement Account** **Total Amount Requested___________**

Please attach proof that employee owns policy.

☐ **Other** _______________________________________ **Total Amount Requested___________**

Date of Service	Employee, Spouse or Dependent	Amount Requested	Type of Service (Rx copay, dental, etc.)	Service Provider / Rx # (MUST be provided)
1.				
2.				
3.				
4.				
5.				

If you are unsure if an expense is eligible for reimbursement, please call AdminUSA at 1-866-99FSA4U (Monday-Friday 8:00 am to 5:30 pm EST). Please note the following requirements for claims submission:

- Please number each receipt according to its order of appearance on this form.
- IRS guidelines do NOT consider cancelled checks as valid documentation.
- Previous balances are NOT acceptable.
- All reimbursements will be made payable to the employee.

To the best of my knowledge and belief, my statements in this reimbursement voucher are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed on this or any other benefit plan and WILL NOT BE CLAIMED AS AN INCOME TAX DEDUCTION. I authorize my Flexible Compensation account be reduced by the amount released.

Employee's Signature ____ Date _______________

For faster service, fax claims to (252) 265-5988 or mail to PO Box 8179, Wilson, NC 27895.

Instructions for Completing
Request for Reimbursement Form

To prevent delays in processing your reimbursement request, please complete this form as follows:

Personal Data (Employee Name, Social Security Number, etc.). In the spaces provided, print your name as it appears on the payroll records and enter your employee number, your correct Social Security number, and the company and plant location at which you work. Be fore to include the mailing address to which you wish your reimbursement check sent. Please indicate if this is a new address.

Name of Service Provider. For health care or dependent care expenses, enter the name of the person or facility that provided the service (for example: the doctor, clinic, day care facility, etc.). Use a separate line for each expense request.

Person Receiving Service. Enter your name or the name of the dependent.

Relationship to the Employee. Enter the dependent's relationship to you (for example: spouse or child).

Date Expense Incurred. Enter the date the expense was incurred, not the date it was paid.

Expense Type. Enter the code for the type of expenses incurred as follows: C=Dependent Care, H=Hearing, O=Over-the-counter Drugs, M=Medical, V=Vision, D=Dental, P=Prescription Drugs.

Reimbursement Request Amount. Enter the amount of the incurred expense.

Total Reimbursement Requested. Add amounts of the reimbursements requested and enter the total. You may submit a claim any time, and checks will be issued on the 15th and the last day of each month. You have SIXTY (60) DAYS FOLLOWING the end of the plan year to request reimbursement of expenses incurred during the plan year.

Employee Signature and Date. Be sure to sign and date your request.

Documentation Needed. You **<u>must</u>** attach copies of required documentation to receive reimbursement. The required documentation includes: For expenses that must be submitted first to an insurance company or health care plan, attach a copy of the Explanation of Benefits form received from the insurance company or claims administrator. For non-covered medical expenses, attach a statement of expense showing the diagnosis, the incurred date, and the amount of expenses (for example, a physician's bill or pharmacist's prescription or receipt). For dependent care expenses, attach a statement of expenses from the provider showing the dependent's name, the incurred date, and the amount of the expense. Include the provider's name, address, and taxpayer identification number on the first claim submitted for that provider. Note: Keep all your original receipts.

Send your completed request form, with the required documentation attached.