Reimbursement Claim Form

Total # Pages Sent: _____

Flexible Spending Accounts

Regular Check by Mail: *Fax-a-Claim* (877) 329-3539 [*877-Fax-Flex*]
Direct Deposit to Bank: *Fax-a-Claim* (866) 329-3539 [*866-Fax-Flex*]

Use the "Direct Deposit" number only if this service is offered by your employer's flex plan.

**All items marked are required for processing.*

*Participant Name _____

Social Security # _____ Day Phone (_____) _____

*Employer _____ Email Address _____

Used to send you a confirmation that claim was received.

☐ Address, if Changed _____

Medical/Dental/Vision Care FSA

Indicate date(s) of service, not payment dates

*Date From ____/____/____

*Date To ____/____/____

*Amount $_____

Dependent Care FSA

Indicate date(s) of service, not payment dates

*Date From ____/____/____

*Date To ____/____/____

*Amount $_____

Per IRS Regulations, *all* claims must be documented with provider receipt(s) indicating the following:

- Dates of Service & Amount of Expense
- Type of Service (e.g., Office Visit, Rx, Childcare)
- Name of Provider (e.g., Doctor, Hospital, Childcare Giver)

Credit/Debit Card slips or Cancelled Checks will not be accepted as valid documentation.

In Addition, for Dependent Care, per IRS regulations...

- Expenses are eligible for children under age 13 or for dependent, disabled adults.
- IRS requires that the name, address, and tax ID number of your childcare provider be given.

Provider Name:_____

SS#/Tax ID#:_____

Address:_____

Comments And Explanations

_____

Certification: These expenses were incurred (have a date of service) by me and/or my spouse or eligible dependents during the plan year while I have been a covered participant and to the best of my knowledge are reimbursable by the plan. I, the participant, certify that I have not been reimbursed for the above expense(s) and that I will not seek reimbursement under any other plan covering health benefits, such as my spouse's health plan. I understand that any expense reimbursed under this Plan may not be used to claim any income tax deduction or credit.
I also understand that privacy regulations prohibit ***Pro*Benefits** from discussing claims with anyone other than the participant.

***Signature** _____ **Dated** _____

Claims Status is online at **www.*Pro*Benefits.com** - click "***FSA Status***"
-or- call ***FlexCall-24*** (888) 722-8382, Option 3

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