FLEXIBLE SPENDING ACCOUNT (FSA) REIMBURSEMENT CLAIM FORM

There are **three ways** to submit eligible expenses for reimbursement through your FSA.

1. Submit a claim **ONLINE** at **www.myFlexDollars.com** and upload your receipts.
2. **FAX** this claim form and your receipts to the Baker Tilly Vantagen FSA Unit at **1-866-406-0946**.
3. **MAIL** this claim form and your receipts to the Baker Tilly Vantagen FSA Unit at 1200 Abington Executive Park, Clarks Summit, PA 18411.

For general questions and account information, visit **www.myFlexDollars.com**. To speak with a customer service representative, call the Employee Benefits Center at **1-800-307-0230**.

SECTION 1 – EMPLOYEE PROFILE (Please Print)

COMPANY NAME: _____ **DAYTIME PHONE #:** _____

SSN (Last Four Digits Only): XXX – XX – _____ **EVENING PHONE #:** _____

EMPLOYEE NAME: _____ **EMAIL ADDRESS:** _____

MAILING ADDRESS: _____ **LOCATION:** _____

_____

DESCRIPTION OF EXPENSES – See Reverse Side for more detailed instructions.

SECTION 2 – HEALTH CARE EXPENSES (Please provide the requested information for each expense on a separate line.)

Dates of Service (MM/DD/YY)		Patient Name*	Relationship to Employee	Name of Provider/Pharmacy*	Description of Service/Medicine/Drug*	Reimbursement Requested*
Start Date	End Date					

Required Information** **Total Reimbursement Requested

SECTION 3 – DEPENDENT CARE EXPENSES (Please provide the requested information for each expense on a separate line.)

Dates of Service (MM/DD/YY)		Dependent Name*	Relationship to Employee	Name of Provider*	Type of Service*	Tax ID # or SSN	Reimbursement Requested*
Start Date	End Date						

Required Information** **Total Reimbursement Requested

SECTION 4 – PROVIDER PAYMENT SECTION (Please provide the requested information for each expense on a separate line.)

Expense Type		Provider Name*	Address*	City*	State*	Zip*	Amount	Frequency*+
☐ Med.	☐ Dep. Care							☐O ☐M
☐ Med.	☐ Dep. Care							☐O ☐M

***Required Information** **+O = One Time, M = Monthly**

SECTION 5 – AUTHORIZATION

I certify that the medical and or dependent care expenses submitted for reimbursement were rendered to me or an eligible member of my family during the period I was a participant in the Health Care and or Dependent Care Flexible Spending Account. I further certify that the medical care expenses are not eligible to be paid by the health care coverage provided through my employer or from any other source, such as my spouse's employer's health plan. I understand that I have the responsibility for any tax reporting or other requirements with respect to reimbursed expenses. I also understand that to the extent medical and or dependent care expenses are reimbursed under the Health and or Dependent Care Flexible Spending Account, they may not be claimed as expenses on my or my spouse's tax return. I also understand that the charges for which I am submitting reimbursement are eligible charges in accordance with IRS guidelines and IRS Publication 502. I certify that all over the counter medicine or drug expenses were incurred for medical care. I agree that I am responsible for any and all bank, savings, or checking account charges that I incur. I agree to indemnify and hold harmless Baker Tilly Vantagen from any responsibility relative to my credit status. I have received and read all printed material describing this program and all administrative materials defining the operation of this plan. I certify that I am responsible for compliance with all applicable administrative processes, tax regulations and documentation. I will retain a copy of this form and all original receipts for my records.

Signature **Date**

INSTRUCTIONS AND HELPFUL HINTS

GENERAL INFORMATION

The Employee Benefits Center must receive your claim(s) and supporting documentation by Noon (EST) on each processing deadline. Call 1-800-307-0230 if you are unsure of your company's processing deadline. If your submitted claims are authorized, you will then receive reimbursement. Some claim reimbursements may be delayed due to coordination of benefits requirements.

SECTION 1 – EMPLOYEE PROFILE

- ☑ Fill in **all** of the requested information.
- ☑ Print or type in your information, so we can process your claim quickly and accurately.

SECTION 2 – HEALTH CARE EXPENSES

- ☑ Fill in **all** of the fields marked with an asterisk (*). This information must be filled in for your claim to be processed.
- ☑ Provide a copy of the Explanation of Benefits (EOB) from your insurance company for qualified expenses (if available).
- ☑ If you are attaching a copy of an itemized statement as proof for a qualified expense, the itemized statement must contain the following information: **(1)** name and address of the provider, **(2)** patient name, **(3)** date of service (i.e. the date on which the service was provided, not the date the service was paid for), **(4)** description of service provided, and **(5)** itemized charges.
- ☑ If you are submitting a claim for a prescription drug, **the prescription number (RX #) must be on the receipt** that you submit with your claim form.
- ☑ Cancelled checks and credit card receipts **ARE NOT** considered acceptable documentation of expenses listed on this form.
- ☑ Over-the-counter medications can only be reimbursed if you submit a prescription AND receipt. **Vitamins, supplements, and hygienic products are not qualified expenses and cannot be reimbursed through your FSA.**
- ☑ For all other expenses you must attach itemized receipts.
- ☑ Only submit copies of receipts, itemized statements, etc., since this documentation **will not** be returned to you.

SECTION 3 – DEPENDENT CARE EXPENSES

- ☑ Fill in **all** of the fields marked with an asterisk (*). This information must be filled in for your claim to be processed.
- ☑ The service(s) you are submitting a claim for **must have occurred. We cannot reimburse payments for future dates of service.**
- ☑ Provide a copy of a receipt or bill from the provider of the service with this form.
- ☑ The bill/receipt submitted along with this form must include the following information for the service provider: **(1)** name, **(2)** address, and **(3)** tax identification number or Social Security Number (if your provider does not have a tax identification number).
- ☑ If there is not enough money in your Dependent Care FSA to pay the entire amount of the claim you submit, the claim will be paid up to the amount currently available in your account. You **do not** need to resubmit this claim again to receive full reimbursement. As more money accumulates in your account, you will automatically be reimbursed up to the full amount of the claim.

SECTION 4 – PROVIDER PAYMENT SECTION

- ☑ **Only complete this section if you are requesting that payment be made directly to your provider.**
- ☑ Fill in **all** of the fields marked with an asterisk (*). This information must be filled in for payment to be made directly to a provider.

SECTION 5 – AUTHORIZATION SECTION

- ☑ Read the Authorization Section carefully.
- ☑ **Make sure to sign and date this form before submitting it for reimbursement.**

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myFlexDollars.com

Don't forget to check out MyFlexDollars.com – your one-stop FSA resource. Log in today to view your account balance, check the status of a claim, file a claim, and more!