HOW TO REQUEST REIMBURSEMENT FROM YOUR HEALTH CARE ACCOUNT

Use this form to request reimbursement for your health care expenses only. To view a detailed list of eligible medical expenses, visit **FSAFEDS Eligible Expenses Juke Box** at **www.FSAFEDS.com**. Remember, you should first submit health care expenses under your FEHB or other health care plan you may have before you request reimbursement from your Health Care Flexible Spending Account.

Use this form only to request reimbursement for:

- Allowable expenses covered, but not fully reimbursed, by any benefit plans. Attach a copy of the plan's Explanation of Benefits Statement (EOB) or itemized receipt from your provider.
- Allowable expenses not covered by any benefit plans. Attach bills or receipts which indicate the name and address of the provider of the product or service and description of the product or service provided.

Step 1: Fill out the form

Please type or print in capital letters, with your letters centered in the boxes provided and fill in all ovals as shown:

A	B	C	D		1	2	3	4

● YES ○ NO

For Section 1: Complete all areas of "Employee Information." You may use your User ID instead of your SSN in part 1 of the claim form. You will receive an email confirming receipt of your claim.

For Sections 2 & 5: Fill in your expense – you can use one line to show a total of multiple expenses within the same Coverage Code. However, the expenses will be processed separately, and will be reflected as separate amounts on your account.

- Complete all sections of the form. Sign and date the bottom of the form.
- Please use page 3 for additional expenses if you exceed the number of lines provided on page 2.

Step 2: Attach supporting documentation. Please refer to the Clean Claim Quick Reference Guide for details.

In addition to completing the form, you must submit the documentation described under EITHER A OR B below:

A. Explanation of Benefits Form (EOB): This is the form you typically receive each time you or a health care provider submit medical, dental or vision claims for payment to your health, dental or vision care plan. The EOB will show the amount of expenses paid by the plan and the amount you must pay. For expenses that are partially covered by your, or your dependent's, or your through age 26 adult child's medical, dental or vision plan(s), you must attach the EOB.

B. All Other Expenses: For expenses not covered at all by your, or your dependent's, or your through age 26 adult child's medical, dental or vision plan(s), or when you do not receive an EOB, your claim must include acceptable evidence of your expenses. A cancelled check is not considered acceptable evidence. Acceptable evidence includes receipts which contain the following information:

- Type of service or product provided
- Date expense was incurred
- Person or organization providing the service and product
- Amount of expense

OTC Medicine/Drugs. Please refer to the OTC Medicines Quick Reference Guide for details. – You must submit copies of the prescription, label of the box/container, as well as your receipt.

OTC Non-Medicine/Drugs – If your receipt does not clearly show the name of the product, you must submit copies of the label from the box/container.

Step 3: Read the Certification and then sign and date the form where indicated

Step 4: Submit your form

- **By Fax:** Fax the form and supporting documentation to 1-866-643-2245 (toll-free). If you are sending from outside the United States, please fax to 1-502-267-2233.
- **By Mail:** Place the form and the supporting documentation into an envelope, apply the correct postage, and mail to FSAFEDS Program, PO Box 36880, Louisville, KY 40233.
- Keep a copy of your completed form and receipts for your records.

Please remember that FSAFEDS has a minimum reimbursement threshold of $25.00. If your claim does not total $25.00, it will be processed and you will receive a reimbursement statement, but your payment will be pended until you submit another claim and reach the $25.00 aggregate amount, or until the end of the quarter, whichever comes first.

COVERAGE CODES – You must include a code in Sections 2 and 5 of the form.

Medical codes

102 = over-the-counter non-drugs/medicines
103 = prescriptions or prescription co-pays
104 = general medical (e.g., co-pays, deductibles)
117 = over-the-counter drugs/medicines (prescription required)
120 = mileage

Other code

999 = other

Dental code

202 = general dental (e.g., cleanings, x-rays, crowns, implants, dentures - or use 102 or 117 for over-the-counter items)
203 = orthodontia

Vision code

303 = general vision (e.g., exams, glasses, contact lenses - or use 102 or 117 for over-the-counter items)

Type of Supporting Documentation:

- Itemized receipt from your medical, dental or vision provider or pharmacy
- Explanation of Benefits (EOB) from your insurance company or health care provider
- Prescription written by your healthcare provider which must include:
  - The date
  - The name of the patient for whom the OTC item is prescribed
  - The name of the OTC item (if you purchase a generic item, you must provide documentation that supports that it is the therapeutic equivalent to the prescribed drug)
  - The dosage requirement (the potency of the item purchased must match the prescribed amount)
  - The number of refills (unless it is a one-time purchase)
  - The provider's address and license number

Helpful Hints:

- Add together similar expenses from the same Coverage Code and place that total on one line (e.g., several over-the-counter items – Code 102, multiple prescription copays – Code 103, etc.). FSAFEDS will process them separately and they will be reflected as separate amounts on your account.
  - Provide the span of dates of service (e.g. 01/01/08 - 06/30/08)
  - Enter the total amount on one line
  - Be sure to include legible receipts for each expense included in the overall total
- Be sure to use your FSAFEDS UserID
- Be sure your signature is legible
- Be sure copies of OTC labels, if required, are clear enough to fax
- The Total Requested box will automatically calculate the sum of expenses you list on page 2, or pages 2 and 3.

Please Do NOT :

- Use red ink
- Use a photocopy of this form
- Use a highlighter on your receipts or any part of the form
- Staple your copied receipts to the form
- Write outside the boxes provided
- Fax the same form more than once
- Mail the same form that you have faxed
- Include this instruction sheet with your fax

Please DO:

- Circle applicable items on your receipts (just don't use a highlighter)
- Use as many sheets for additional expenses as you need
- Use code 999 for any eligible item that isn't covered by one of the other Coverage Codes

Questions? Need a list of eligible expenses? Go to www.FSAFEDS.com or contact an FSAFEDS Benefits Counselor at 1-877-FSAFEDS.

MAIL: FSAFEDS Program
PO Box 36880
Louisville, KY 40233

PHONE: 1-877-FSAFEDS
(1-877-372-3337)
TTY:1-800-952-0450

HEALTH CARE CLAIM FORM

Use only CAPITAL LETTERS

FAX TO: 1-866-643-2245 TOLL-FREE or 1-502-267-2233

For additional expenses, please use next page.

WKBVDY

SECTION 1: EMPLOYEE INFORMATION

EMPLOYEE USER ID (NO DASHES)

PROGRAM NAME: FSAFEDS

INTERNAL USE ONLY

EMPLOYEE LAST NAME

EMPLOYEE FIRST NAME

EMPLOYEE EMAIL

DAYTIME PHONE # (AREA CODE FIRST, NO DASHES)

SECTION 2: YOUR HEALTH CARE EXPENSES

EXPENSE 1

Please Select Code

DATES OF SERVICE FROM (MMDDYY)

AMOUNT REQUESTED (DOLLARS . CENTS)

$.

SUPPORTING DOCUMENTATION ATTACHED? ○ YES ○ NO

COVERAGE CODE (SEE PAGE 1)

TO (MMDDYY)

FAMILY MEMBER'S NAME

EXPENSE 2

Please Select Code

DATES OF SERVICE FROM (MMDDYY)

AMOUNT REQUESTED (DOLLARS . CENTS)

$.

SUPPORTING DOCUMENTATION ATTACHED? ○ YES ○ NO

COVERAGE CODE (SEE PAGE 1)

TO (MMDDYY)

FAMILY MEMBER'S NAME

TOTAL REQUESTED (SUM OF EXPENSES FROM ALL PAGES SUBMITTED)

$ 0.00

SECTION 3: CERTIFICATION Please read carefully before signing.

I affirm that:

- I HAVE NOT ALREADY BEEN PAID FOR THESE EXPENSES FROM MY FSA AND I HAVE NOT REQUESTED and WILL NOT RECEIVE REIMBURSEMENT FOR THESE EXPENSES FROM ANY OTHER PLAN INCLUDING FEDVIP (Federal Employees Dental and Vision Insurance Program) and FEHB (Federal Employees Health Benefits Program); AND
- I have submitted the above information in good faith and it is correct to the best of my knowledge.

I understand that:

- Reimbursement is not a guarantee that this payment is tax-free.
- The service(s) for which I am requesting reimbursement must be incurred during my period of coverage, which begins the next January 1 if I enrolled during the Open Season, or the day after my enrollment is accepted by FSAFEDS, whichever is later, and ends no later than March 15 of the following year, unless my coverage ends sooner due to a Qualifying Life Event.
- I have until April 30 following the end of the Benefit Period or end of Federal Service to submit my claim for reimbursement of eligible expenses incurred during my period of coverage. If I do not submit claims for reimbursement by that date, I will forfeit any funds remaining in my account(s) in accordance with IRS rules.
- I cannot use health care expenses reimbursed through my general purpose HCFSA or LEX HCFSA as a deduction on my personal income tax return.
- The expenses for which I am requesting reimbursement are for myself, my spouse, my dependent or adult child through age 26.

I authorize release of payment through my Flexible Spending Account. I authorize FSAFEDS, or its representatives, to obtain necessary information from all physicians, hospitals, medical service providers, pharmacists, employers, and all other agencies or organizations (including other insurers) to consider the claim for reimbursement under my Flexible Spending Account.

Employee Signature* _____ **Date** (MMDDYY)

*Your signature and date are required in order to process your claim for reimbursement.

USE AN ORIGINAL FORM (NOT A PHOTOCOPY)

WKBVDY

USE THIS PAGE FOR ADDITIONAL HEALTH CARE EXPENSES.

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SECTION 4: EMPLOYEE INFORMATION (ABBREVIATED)

EMPLOYEE USER ID (NO DASHES)

EMPLOYEE LAST NAME

EMPLOYEE FIRST NAME

SECTION 5: YOUR ADDITIONAL HEALTH CARE EXPENSES

EXPENSE 3

Please Select Code

DATES OF SERVICE FROM (MMDDYY)

TO (MMDDYY)

AMOUNT REQUESTED (DOLLARS . CENTS)

$.

SUPPORTING DOCUMENTATION ATTACHED? ( ) YES ( ) NO

COVERAGE CODE (SEE PAGE 1)

FAMILY MEMBER'S NAME

EXPENSE 4

Please Select Code

DATES OF SERVICE FROM (MMDDYY)

TO (MMDDYY)

AMOUNT REQUESTED (DOLLARS . CENTS)

$.

SUPPORTING DOCUMENTATION ATTACHED? ( ) YES ( ) NO

COVERAGE CODE (SEE PAGE 1)

FAMILY MEMBER'S NAME

EXPENSE 5

Please Select Code

DATES OF SERVICE FROM (MMDDYY)

TO (MMDDYY)

AMOUNT REQUESTED (DOLLARS . CENTS)

$.

SUPPORTING DOCUMENTATION ATTACHED? ( ) YES ( ) NO

COVERAGE CODE (SEE PAGE 1)

FAMILY MEMBER'S NAME

EXPENSE 6

Please Select Code

DATES OF SERVICE FROM (MMDDYY)

TO (MMDDYY)

AMOUNT REQUESTED (DOLLARS . CENTS)

$.

SUPPORTING DOCUMENTATION ATTACHED? ( ) YES ( ) NO

COVERAGE CODE (SEE PAGE 1)

FAMILY MEMBER'S NAME

EXPENSE 7

Please Select Code

DATES OF SERVICE FROM (MMDDYY)

TO (MMDDYY)

AMOUNT REQUESTED (DOLLARS . CENTS)

$.

SUPPORTING DOCUMENTATION ATTACHED? ( ) YES ( ) NO

COVERAGE CODE (SEE PAGE 1)

FAMILY MEMBER'S NAME