Submit Claims By:
Fax: 1-502-267-2233
Mail: FSAFEDS
PO Box 36880
Louisville, KY 40233
Form instructions are located on page 2.

Questions?
1.) Online account information: www.FSAFEDS.com
2.) Automated Account Information: **1-877-FSAFEDS (372-3337)**
3.) Customer Service: **1-877-FSAFEDS (372-3337) TTY: 1-800-952-0450**
4.) Email: FSAFEDS@shps.net

FSAFEDS Claim Form

Control # 10779

Part I: Employee Information (Please Print) *(If you wish to update your address, please visit the web site at www.FSAFEDS.com)*

Employee Name (Last/First/MI)	**Employee SSN/Alternate ID**
E-mail Address (*Completion of e-mail address will enroll you to receive e-mail correspondence about your account.*)	**Daytime Telephone Number**

Part II: Health Care Expenses Family Member	Type(s) of Service Medical, Dental, Vision, Rx, Over-the-Counter (OTC), Orthodontia, Supply	Description of Medicine/Product Service or Supply*	Date(s) of Service	Reimbursement Request Amount
Example: John	OTC	Tylenol	01/04/04	$7.50
1.				
2.				
3.				
4.				
5.				
			Total:	

*Note: The name of prescription is not required, however, the name of any over-the-counter medicines is required.

Affidavit of Non-covered Medical, Dental, Vision, or Pharmacy Expenses: (*Your signature is required if you are* ***not*** *submitting an EOB Statement. You do not need to complete this section if you are requesting reimbursement of a co-payment, or OTC medicine or product.***)**

I affirm that any expenses claimed here have not, and will not, be reimbursed by my FEHB or any other insurance plan.

Employee Signature: ____ Date: ____________________

Part III: Dependent Care Expenses *(Child care or elder care expenses)*

Reimbursement Request Amount	**Provider's Signature** (*required if receipt is not provided*)	**Provider Tax ID or SSN** (required)
Dates(s) of Service	**Provider's Address**	**Age of Dependent(s) at Time of Service**

Part IV: Employee's Certification for Reimbursement

I affirm that:
- I have submitted the above information in good faith and it is correct to the best of my knowledge;
- I have not received reimbursement previously for these expenses from my Flexible Spending Account(s) or any other plan; and
- The total of any reimbursed dependent care expenses does not exceed my or my spouse's earned income (W-2 Pay) for the year, if either of our annual incomes is less than $5,000.

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 December 31 of that same year, unless my coverage ends sooner due to a Qualified Status Change.
- I have 120 days following the end of the plan year 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.
- Health care expenses reimbursed through my Health Care Flexible Spending Account cannot be used as a deduction on my personal income tax return.
- Dependent care expenses reimbursed through my Dependent Care Flexible Spending Account (DCFSA) cannot be used as a dependent care credit on my personal tax return. Therefore, reimbursement of dependent care expenses reduces, and may eliminate completely, my ability to claim a dependent care credit on my personal income tax return.
- Dependent care expenses qualify if they are for the care of my children under age 13 or my other dependents who are physically or mentally incapable of caring for themselves and includes anyone I claim on my Federal Income Tax return as a qualified IRS dependent. These expenses must be incurred so that my spouse and I, if married, can work, look for work or my spouse can attend school full-time.
- My household limit for dependent care reimbursement cannot exceed $5,000 per year, including my annual election, any childcare subsidies that I receive, and/or amounts that my spouse has elected through another account.
- The balance in my DCFSA must be at least equal to the expenses submitted with this claim. If the balance in my DCFSA is less, these expenses will be held until the balance in my account is sufficient to pay these expenses.
- I can only be reimbursed for my DCFSA expenses after the date of service has passed.

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

Employee Signature* ________________________________ **Date*** ______________________________

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

FSAFEDS Claim Form Instructions

Please read these instructions before completing the form.

1. Complete all areas of Part I “Employee Information.”

2. Where applicable, complete Part II “Health Care Expenses” and/or Part III “Dependent Care Expenses.”

3. All health care expenses should first be filed under your employer’s health care plan or any other coverage you may have before you request reimbursement from your Flexible Spending Account.

4. This form is to be used only to request reimbursement for:

   Health Care Expenses
   - Allowable expenses covered, but not fully reimbursed, by any benefit plans. Attach a copy of the plan’s Explanation of Benefits Statement (EOB) as documentation.
   - Allowable expenses not covered by any benefit plans. Attach bills or receipts which indicate the name and address of the provider of service. **Please note on the form if the expense(s) are not covered by your health, dental, or vision plan. Additionally, you must sign the “Affidavit of Non-covered Medical, Dental, or Vision Expenses”.**

   Supporting Documentation – Health Care Expenses
   In addition to the completion of the form, the documentation described under either A or B below must be attached to this form:
   A. **Explanation of Benefits Form (EOB):** This is the form you 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) medical, dental or vision plans, you must attach the EOB. If you are covered under a HMO/DMO indicate “Co-pay” on Part II under “Type(s) of Service.”
   B. **All Other Expenses:** For expenses not covered at all by your (or your dependent’s) medical, dental or vision plans, reimbursement requests will not be processed without acceptable evidence of your expenses. A cancelled check is not considered acceptable evidence. Acceptable evidence includes copies of the Universal Product Code (UPC) and/or boxes for over-the-counter (OTC) products and receipts, which contain the following information:
      - Type of service or product provided
      - Date expense was incurred
      - Person or organization providing the service/product
      - Amount of expense
      - **Additionally, you must sign the "Affidavit of Non-covered Medical, Dental, or Vision Expenses" on the**
      - reverse side.

   Dependent Care Expenses – In general, the following rules apply to dependent care expenses:
   - Dependent care expenses qualify if they are for the care of children or other dependents that are physically or mentally incapable of caring for himself or herself. These expenses must be incurred so that you and your spouse, if married, can work, or your spouse can attend school full-time.
   - Children must be under age 13.
   - Services provided by a childcare or elder care center must comply with all state and local laws to be an eligible reimbursement expense.

   The annual amount of dependent care claims cannot exceed:
   - Your annual deposit amount up to $5,000 ($2,500 if you and your spouse are filing separate returns), or
   - Your annual salary or your spouse’s annual salary, if less than $5,000
   - Your annual election plus any childcare subsidies cannot total more than $5,000.

   Supporting Documentation – Dependent Care Expenses
   - For allowable Dependent (Day) Care expenses, attach a copy of the bill or signed receipt, or have the provider complete Part III, “Affidavit of Day Care Services Rendered” on the reverse side.
   - Requests **will not be processed** without the Tax ID Number or Social Security Number for all providers.

5. Read the Employee’s Certification for Reimbursement Statement, then sign and date the form where indicated.

6. Mail this form to the address listed at the top of this page or fax it to 1-502-267-2233.