HEALTH CARE FSA CLAIM FORM

Mail or Fax To:
BAS
P.O. Box 62407
King of Prussia, PA 19406
FAX: 1.888.265.2144

Please type or print legibly.

*** Required Fields**

EMPLOYEE'S NAME * FULL NAME _____ * EMPLOYER	WORK PH # WORK EXT HOME PH #
EMPLOYEE'S STREET ADDRESS * CITY * STATE * ZIP	
Please complete this Dependent Section only if you are submitting health care reimbursement claims for a dependent. Please note: A separate claim form must be used for each dependent's claims. **DEPENDENT'S NAME** FULL NAME _____ DATE OF BIRTH	**DEPENDENT'S STATUS** ☐ Over-Age Tax Dependent

CLAIM EXPENSE INFORMATION

CLAIM YEAR ☐ * DATE OF SERVICE (MM/DD) FROM	TO	* HEALTH CARE PROVIDER'S NAME	DESCRIPTION OF SERVICES RECEIVED	CLAIM AMOUNT
			TOTAL =	

HEALTH CARE FLEXIBLE SPENDING ACCOUNT CERTIFICATION

I certify that the expenses submitted herewith were incurred during the plan year and qualify for reimbursement as expenditures for medical care and not merely for general health or cosmetic purposes. The expenses have been incurred and paid by my spouse, my eligible dependent(s), or me and have not or will not be reimbursed from any other health plan, insurance, or any other source. The expenses have not or will not be claimed as deductions in filing income tax returns. I understand that if an expense is determined to be ineligible, I am responsible for reimbursing my plan for the expense. I understand that if there is a discrepancy between the total amount of expenses I requested and the total amount of the attached receipts, I will be reimbursed according to the total amount of eligible expenses on the attached receipts. These expenses have not been and will not be reimbursed from any other source.

X _____

SIGNATURE DATE

* Benefit Allocation Systems, LLC / MyEnroll.com does not insure benefits under the health care flexible spending account plan. Your employer is solely responsible for determination of entitlement to, and payment of, any amounts due under the plan. Refer to the plan documents for more details.

PO Box 62407, King of Prussia, PA 19406
T.800.945.5513 F.888.265.2144
www.BASusa.com

FLEXIBLE SPENDING ACCOUNTS

Employee instructions and information for completing this claim form.

1. Complete all employee information questions.
2. If the claim expenses are for a dependent, complete dependent section.
3. Submit a separate claim form for each family member's expenses.
4. Indicate the dates the expense is incurred, name of provider along with a brief description of the services and the amount of reimbursement you are requesting.
5. When requesting reimbursement for medical expenses, you must provide adequate documentation. Generally, a copy of the Explanation of Benefits (EOB) provided by the primary insurer is acceptable, as is documentation from a provider that meets ALL IRS requirements for adequate substantiation.
6. Be sure to attach documentation, including itemized receipts, for all items to be reimbursed. Claims for all expenses without adequate documentation will be denied. If you are submitting claims for items that have both a medical and non-medical purpose, you must provide a completed Letter of Medical Necessity from a physician. If you are submitting dependent day care claims, use the Dependent Care Reimbursement Form.
7. Itemizing Expenses vs. Entering A Grand Total. On the claim form, you have the choice of itemizing your claim expenses or entering a "Grand Total" of your claim expenses. Itemize your claim expenses if you want a detailed listing of your submission. Enter a Grand Total of your claim expenses if you simply want to indicate the total of all your claim expenses.

   If you choose to enter a Grand Total, complete the first line of the "Claim Expense Information" section as follows:

   - Dates of Service From: Enter the earliest service date of all claim expenses
   - Dates of Service To: Enter the most current date of all claim expenses
   - Health Care Provider's Name: Enter "See Receipts"
   - Description of Services: Choose "Grand Total"
   - Claim Amount: Enter the total amount of requested reimbursement

8. Once the form is completed, forward the form with the attached receipts to the address for BAS located above. You should print and save your claim form for future reference.
9. A request for reimbursement which is not supported by proper documentation or does not qualify as a reimbursable expense under the employer's plan will be denied.
10. If you have questions regarding submitting your claims, please contact Benefit Allocation Systems, LLC at 1-800-945-5513 or info@BASusa.com.