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 service and description of 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: Complete a separate line for each individual expense. Do not lump expenses together.

- 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

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 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. Please refer to the list of codes below.

B. All Other Expenses: For expenses not covered at all by your (or your dependent's) medical, dental or vision plans, 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

If your receipt does not clearly show the name of the product or service provided, you will need to submit copies of the Universal Product Code (UPC) and/or copies of the front of the box/container for over-the-counter (OTC) products and services.

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 40232.
- 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.

If you do not select a Plan Year, we will default to the appropriate year according to the date of service, up to the available balance.

Type of Supporting Documentation:

- Itemized receipt from your medical, dental or vision provider or pharmacy
- Itemized receipt for over-the-counter medicines – must show the name of the product
- Explanation of Benefits (EOB) from your insurance company or health care provider
- Documentation must show:
  - Date expense was incurred
  - Type of service or name of product
  - Amount (your portion of payment)
  - Person or organization providing the service and product

Please Do NOT :

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

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

Medical codes

102 = over-the-counter medicines
103 = prescriptions or prescription co-pays
104 = general medical

Other codes

999 = other

Dental codes

202 = general dental (cleanings, x-rays, crowns, implants, dentures)

Vision codes

303 = general vision (exams, glasses, contact lenses)

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 40232

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.

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SECTION 1: EMPLOYEE INFORMATION

EMPLOYEE USER ID (NO DASHES)

○ 2007 PLAN YEAR

○ 2008 PLAN YEAR

PROGRAM NAME: FSAFEDS

FOR SHPS USE

EMPLOYEE LAST NAME

EMPLOYEE FIRST NAME

EMPLOYEE EMAIL

DAYTIME PHONE # (AREA CODE FIRST, NO DASHES)

SECTION 2: YOUR HEALTH CARE EXPENSES

EXPENSE 1

COVERAGE CODE (SEE PAGE 1)

DATES OF SERVICE (MMDDYY)
FROM

TO (MMDDYY)

AMOUNT REQUESTED (DOLLARS . CENTS)

$.

FAMILY MEMBER

COVERED BY INSURANCE? ○ YES ○ NO

EOB ATTACHED? ○ YES ○ NO

EXPENSE 2

COVERAGE CODE (SEE PAGE 1)

DATES OF SERVICE (MMDDYY)
FROM

TO (MMDDYY)

AMOUNT REQUESTED (DOLLARS . CENTS)

$.

FAMILY MEMBER

COVERED BY INSURANCE? ○ YES ○ NO

EOB ATTACHED? ○ YES ○ NO

SECTION 3: CERTIFICATION Please read thoroughly 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 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 general purpose HCFSA or LEX HCFSA cannot be used as a deduction on my personal income tax return.

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 __________

* Your signature is required in order to process your claim for reimbursement.

USE AN ORIGINAL FORM (NOT A PHOTOCOPY)

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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

COVERAGE CODE (SEE PAGE 1)

DATES OF SERVICE (MMDDYY)
FROM

AMOUNT REQUESTED (DOLLARS . CENTS)

$.

COVERED BY INSURANCE?
YES NO

TO (MMDDYY)

FAMILY MEMBER

EOB ATTACHED?
YES NO

EXPENSE 4

COVERAGE CODE (SEE PAGE 1)

DATES OF SERVICE (MMDDYY)
FROM

AMOUNT REQUESTED (DOLLARS . CENTS)

$.

COVERED BY INSURANCE?
YES NO

TO (MMDDYY)

FAMILY MEMBER

EOB ATTACHED?
YES NO

EXPENSE 5

COVERAGE CODE (SEE PAGE 1)

DATES OF SERVICE (MMDDYY)
FROM

AMOUNT REQUESTED (DOLLARS . CENTS)

$.

COVERED BY INSURANCE?
YES NO

TO (MMDDYY)

FAMILY MEMBER

EOB ATTACHED?
YES NO

EXPENSE 6

COVERAGE CODE (SEE PAGE 1)

DATES OF SERVICE (MMDDYY)
FROM

AMOUNT REQUESTED (DOLLARS . CENTS)

$.

COVERED BY INSURANCE?
YES NO

TO (MMDDYY)

FAMILY MEMBER

EOB ATTACHED?
YES NO

EXPENSE 7

COVERAGE CODE (SEE PAGE 1)

DATES OF SERVICE (MMDDYY)
FROM

AMOUNT REQUESTED (DOLLARS . CENTS)

$.

COVERED BY INSURANCE?
YES NO

TO (MMDDYY)

FAMILY MEMBER

EOB ATTACHED?
YES NO

USE AN ORIGINAL FORM (NOT A PHOTOCOPY)

FBZSHXP