

I have provided some additional information to submit claims. Feel free to distribute this as necessary.

**1. Manual Claims**

- a. Depending on which account you want to make the claim for, use the appropriate form (attached) and email/fax/mail/drop off with the appropriate receipt information.
  - i. Appropriate receipts include Date of Service, Provider information, Participant identification, General service information, cost.

**2. Online Claims**

- a. For the tech savvy participants, claims can be submitted online and through our mobile app.
- b. Visit our site, [www.mai-ky.com](http://www.mai-ky.com)
- c. On the home page is a red box titled "LOGIN PORTALS", Click
- d. Select FSA/HRA EMPLOYEE PORTAL LOGIN
- e. Because you have the 2 separate accounts (FSA & HRA), there are 2 separate logins, depending on which account you want to file under:
  - i. HRA Account
    - 1. User Name: (first initial)(last name)(Last 4 of SSN)
    - 2. Password: (Whole SSN, no dashes)
      - a. Users should be prompted to change this password after their first login
  - ii. FSA Account
    - 1. User Name: (first initial)(last name)(Last 4 of SSN)fsa
      - a. Notice the "fsa" suffix for the FSA account
    - 2. Password: (Whole SSN, no dashes)
      - a. Users should be prompted to change this password after their first login
- f. Once a user accesses their account, there is a clear box on the left saying "I want to: Submit a Claim"
  - i. Select whether you want to be paid or someone else (i.e. a provider)
  - ii. It will walk you through the rest.



ACA Reporting & Consulting, FSA, HSA, HRA, COBRA, Retirement Plans, FMLA and Retiree Billing

**Affordable Care Act Questions?**  
**Click Here**



997 Governors Lane, Suite 175  
Lexington, KY 40513  
[www.mai-ky.com](http://www.mai-ky.com)

Phone: (859) 233-4377 x235  
Toll Free: (866) 233-4377  
Fax: (859) 255-2999

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## REIMBURSEMENT CLAIM FORM FLEXIBLE SPENDING ACCOUNTS

<b>EMPLOYER:</b>					
<b>NAME:</b>	LAST	FIRST	MI	SS#:	
<b>ADDRESS:</b>	STREET	CITY	STATE	ZIP	<b>PHONE :</b> (    )

PLEASE CHECK IF YOUR NAME OR ADDRESS HAS CHANGED.

*\*INFORMATION BELOW MUST BE COMPLETED. PLEASE ATTACH THE REQUIRED DOCUMENTATION NEEDED TO SUBSTANTIATE THE EXPENSES LISTED BEFORE SUBMITTING THIS CLAIM. CREDIT CARD/DEBIT CARD RECEIPTS AND CANCELLED CHECKS ARE NOT ALLOWED DOCUMENTS PER IRS REGULATIONS.*

MEDICAL EXPENSE CLAIMS				
DATE OF SERVICE MM/DD/YY	CLAIMANT'S NAME	RELATIONSHIP	DESCRIPTION OF SERVICE	CLAIM AMOUNT
				\$
				\$
				\$
				\$
				\$
				\$
				\$
			<b>TOTALS:</b>	\$ 0.00

DEPENDENT CARE (CHILD CARE) CLAIMS				
DATE OF SERVICE FROM    TO	DEPENDENT'S NAME	DEPENDENT CARE PROVIDER NAME	DEPENDENT CARE PROVIDER ADDRESS AND TAX ID# OR SS #	CLAIM AMOUNT
				\$
				\$
				\$
				\$
				\$
				\$
				\$
			<b>TOTALS:</b>	\$ 0.00

### EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I CERTIFY THAT THE EXPENSES FOR REIMBURSEMENT REQUESTED FROM MY ACCOUNTS WERE INCURRED BY ME (AND/OR MY SPOUSE AND/OR ELIGIBLE DEPENDENTS), WERE NOT REIMBURSED BY ANY OTHER PLAN, AND, TO THE BEST OF MY KNOWLEDGE AND BELIEF, ARE ELIGIBLE FOR REIMBURSEMENT UNDER MY REIMBURSEMENT PLANS. I (OR WE) WILL NOT USE THE EXPENSE REIMBURSED THROUGH THIS ACCOUNT AS DEDUCTIONS OR CREDITS WHEN FILING MY (OUR) INDIVIDUAL INCOME TAX RETURN.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY, ADMINISTRATOR, OR PLAN SERVICE PROVIDER, FILES A STATEMENT OF CLAIM CONTAINING FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.

EMPLOYEE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Fax To: (859) 255-2999  
Or Mail To: McGregor & Associates, Inc.  
997 Govenors Lane Suite 175 Lexington, KY 40513

## Claim Filing Instructions

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1. **Print your name, address and social security number.** Be sure to indicate your Employer's name. Please indicate if your address has changed.
2. **List expenses by date & arrange the supporting statements in the same order.** If you have several statements from the same provider, you may subtotal them and list them on one line with a range of service dates.
3. **Attach required documentation.** A written receipt and/or statement from the service provider must be attached showing:
  - The name of the medical service provider or child care provider;
  - The date or range of dates of service for the medical care or day care provided. Although this date may be the same as the date paid, it must be clear on what date the service was provided. You can only be reimbursed for expenses occurring during the current plan year;
  - A description of the service provided (for example, doctor's office visit or day care);
  - The name of the person or persons receiving the medical care or child care; and
  - The cost of the service, not just the amount paid.
3. **Sign** the claim form.
4. **Keep** copies for your tax records.
5. **Fax or mail to:**  
**McGregor & Associates, Inc.**  
**997 Governors Lane, Suite 175**  
**Lexington, KY 40513**  
**(859) 255-2999 Fax**

Requests submitted without adequate claims documentation cannot be processed and will be returned. IRS Regulations stipulate that *cancelled checks and charge card receipts are NOT acceptable documentation.*

**Orthodontics:** Requests may be reimbursed for a reasonable monthly payment on or after the payment is due and paid. The payment must be a reasonable approximation of the value of each month's service. You may only file claims for orthodontic payments while treatment is in process. You must submit a paid receipt from your orthodontist or a photocopy of the monthly payment coupon. Pre-payments are not allowed.

## Additional Account Rules

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1. You can submit a claim at any time during the plan year and for a specified period after the plan year ends, as described in the Summary Plan Description (SPD).
2. If you terminate employment, you can submit a claim for a specified period after the date of termination if so stated in the SPD, as long as the service was incurred prior to your termination date.
3. IRS rules stipulate that any money left in your account(s) at the end of the plan year cannot be carried forward or returned.
4. You cannot submit a claim for a service period that begins in one plan year and ends in the next plan year. File two reimbursement claims, one for each plan year.
5. For dependent care expenses, you cannot claim expenses if the service provider is your child or stepchild and under age 19 or if you claim the service provider as a dependent for Federal income tax purposes.