C.H. Reams & ASSOCIATES, INC
Our service is your benefit!

FLEXIBLE SPENDING ACCOUNT (FSA) REIMBURSEMENT CLAIM FORM

FAX # (814) 459-8600 or Email: FSAClaims@CHReams.com

Office # (814) 453-4357 or (800) 673-2518

Reimbursement and Claim Filing Instructions are on Back of Form

Company Name:		**Phone #**	
Employee Name:			
Employee Address:			

☐ **Please Check if New Address**

24-Hour  **FSA Balance/Transaction Inquiry: 888-523-4308**

All Information Must Be Completed

FSA MEDICAL EXPENSE CLAIMS

Service Date	Patient Name	Relationship	Provider Name	Description of Service	Claim Amount
					$ $ 0.00
					$ $ 0.00
					$ $ 0.00
					$ $ 0.00
					$ $ 0.00
					$ $ 0.00
					$ $ 0.00
					$ $ 0.00
					$ $ 0.00
					$ $ 0.00
					$ $ 0.00
					$ $ 0.00

DEPENDENT CARE CLAIMS DCAP (Day Care Expenses)

Service From	Dates To	Dependent Name	Age	Dependent/Day Care Name	Dependent Care Provider Address	Daycare Provider Tax Id# or SS#	Claim Amount
							$ $ 0.00
							$ $ 0.00
							$ $ 0.00
							$ $ 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:** _____

(Required to Process Reimbursement)

Flexible Spending Account (FSA & DCAP) Claim Form & Filing Instructions

When Completing a FSA or DCAP Claim please:

- Ø Complete FSA or Dependent Care (DCAP) Section of Claim Form
- Ø A Signature is Required to process claims
- Ø Attach copies of your Receipts, Invoices, Medical EOB's or Rx Stubs
  (If you provide a statement-it must have Dates of Service in order to be accepted)
- Ø The Supporting FSA/DCAP Documents must contain the following information:
  - § **Patient/Individual Name who Received Services**
  - § **Date Expense or Services were rendered/incurred**
  - § **Type of Service - or - Name of Product**
    (if Product Name is not on Receipt, a copy of Product Label can be included w/Claim Form)
  - § **Amount of Charge(s)**
  - § **Provider Name (Tax ID # required for DCAP claims)**

NOTE: ***A copy of a cancelled check, credit card receipt, and statements do not meet the requirements for acceptable supporting documentation.***

- Ø If you need a list of FSA Eligible Expenses or have any questions, please contact your TPA Administrator at C.H. Reams at **(814) 453-4357 or (800) 673-2518**
- Ø The MySourceCard  automated number for checking balances is **(888) 523-4308**

Fax or Email Claim Forms To:

Fax Number: (814) 459-8600

-OR-

FSAClaims@CHReams.com

Mail Claim Forms To:

C. H. Reams & Associates, Inc.
401 Cranberry Street, Suite 100
Erie, PA 16507

Supporting Documentation will not be Returned
Please retain copies of all documents for your records

Revised 11/13/18