

Our service is your benefit!

Company Name:

FLEXIBLE SPENDING ACCOUNT (FSA) REIMBURSEMENT CLAIM FORM

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

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

Phone #

Reimbursement and Claim Filing Instructions are on Back of Form

Employee Name:		:								
Employe	e Addres	s:								
Please	e Check if	New Addres	s	2	24-Hour	FSA Baland	ce/Transac	ction Inquiry:	888	3-523-4308
All Information	on Must Be Co	ompleted_	F	SA MEDIC	AL EX	PENSE CLAIM	1S			
Service Patient Name			Relationship	Provider Name		Description of Service		Claim Amount		
									\$	
									\$	
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		DEPENI	DENT	Γ CARE CL		, 	are Expe			
Service Dar From To	lene	ndent Name	Age	Dependent/Day Care Name		Dependent Provider Ad		Daycare Provide Tax Id# or SS		Claim Amount
										\$
										\$
										\$
EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT										\$
plan, and, to the account as ded	ny person wh	inowledge and belints when filing my o knowingly and	quested frief, are e (our) ind	rom my accounts we ligible for reimburs ividual income tax r ent to injure, defrau	ere incurred be ement under seturn. ud, or deceiv	y me (and/or my spouse an my Reimbursement Plans. e any insurance compan	d/or eligible der I (or we) will n y, administrato	ot use the expense re	imbur rovide	sed through this er,
	illes a stateme	ent of claim conta	aining ta	ise, incomplete or	misieading i	nformation may be guilty	or a criminal a	ict punisnable unde	r Iaw.	
Employee Signature: Date:										
(Required to Process Reimbursement)										

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

When Completing a FSA or DCAP Claim please:

- © Complete FSA or Dependent Care (DCAP) Section of Claim Form
- A Signature is Required to process claims
- 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)
- ∅ 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.

- ∅ 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
- ∅ 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