

FLEXIBLE SPENDING ACCOUNT (FSA) REIMBURSEMENT CLAIM FORM

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

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

Reimbursement and Claim Filing Instructions are on the Back of this Form

Company Name:	Phone #	
Employee Name:		
Employee Address:		

Please Check if New Address

24-Hour FSA Balance/Transaction Inquiry: 855-226-5045

All Information Must Be Completed FSA MEDICAL EXPENSE CLAIMS						
Service Date	Patient Name	Relationship	Provider, Facility, or Store	Service/OTC Product	Claim Amount	
					\$	
					\$	
					\$	
					\$	
					\$	
					\$	
					\$	
					\$	
					\$	
					\$	
					\$	
					\$	
DEPENDENT CARE CLAIMS DCAP (Day Care Expenses)						

DEPENDENT CARE CLAIMS DCAP (Day Care Expenses) Service Dates From To Dependent Name Age Dependent/Day Care Name Dependent Care Provider Address Daycare Provider Tax Id# or SS# Claim Amount Image: Imag

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:

(Required to Process Reimbursement)

Date: ____/___

\$

Flexible Spending Account Claim Form & Filing Instructions

When Completing an FSA Claim please:

- Complete FSA Section of Claim Form
- > A Signature is Required to process your claim
- Attach copies of 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 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
 - Provider Name

<u>NOTE</u>: A copy of a cancelled check, credit card receipt, or statement does not meet the requirements for supporting claim documentation.

- If you need a list of FSA Eligible Expenses (including over the counter items) or have any questions, please contact your TPA Administrator at C. H. Reams (814) 453-4357 or (800) 673-2518
- > The SummitCard _____ automated number for checking balances is (855) 226-5045



Supporting Documentation will not be Returned Please retain copies of all documents for your records Revised 07-14-23