FSA Health Care Reimbursement Claim Form

Please read instructions and requirements on reverse side

_____ _____-_____-_____

Name: Last, First, MI Social Security Number

_____ _____

Street Address City, State, ZIP

Health Care Flexible Spending Account

Date Service Provided	Name of Service Provider/Store	Expense Description	Name, SSN, DOB and relationship of Person for whom expense incurred	Claim Amount	OFFICE USE ONLY

TOTAL HEALTHCARE REIMBURSEMENT REQUESTED: _____

*Please attach all necessary documentation and arrange documentation in the order listed above.
**Claims for future services will not be accepted.

The undersigned Participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under his/her employer's Flexible Spending Plan. The Participant also certifies that the expenses have not been reimbursed and are not reimbursable from any other source. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim, which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense.

_____ _____

Employee Signature Date

Helpful Tips for completing your Flexible Spending Account Claim

1. **Complete**, **sign** and **date** the claim form. Failure to complete all areas can result in a delay in processing and claim reimbursement.
2. **Do not** submit Health Care or Dependent Care claims until after services are rendered.
3. Attach a legible receipt (or receipts) from the service provider showing:
    a. A **description** of the services or list of supplies furnished.
    b. The **charge(s)** for each service.
    c. The **date(s)** of service.
    d. The **name** of person(s) receiving service.
    e. The **name** of the **person** providing services or **store** where supplies purchased.

    NOTE: Drug receipts must clearly show the drug name. Balance due statements and credit card receipts are not valid receipts unless they indicate all of the required information listed above. Never send in receipts without an accompanying claim form.
4. The service provider's signature on the claim form can be substituted for a receipt.
5. Verify that the services received are indeed eligible expenses. (Please refer to list of FSA guidelines and eligible expenses)
6. If you carry group insurance, submit expenses to the insurance carrier first. Attach the Explanation of Benefits (EOB) to document any reimbursement or credit to your deductible or coinsurance amounts.
7. The deadline for submitting claims is Mar. 31st of the next year, for services rendered during the Plan Year.
8. Checks will not be written for less than $5.00. Requests for less than $5.00 will be applied to future requests.

How to Submit your completed claim form and documentation to Bouchey & Clarke Benefits, Inc.

1. **Fax** completed Claim Form along with documentation to: 518-874-5002
   Please use discretion when faxing your personal medical information. You bear full responsibility for any inappropriate use or disclosure that may arise in connection with your transmission of information to BCBI.
2. **Scan and Email** to sdawes@bouchey.com.
3. **Mail** completed form and documentation to:
   Bouchey & Clarke Benefits, Inc.
   PO Box 1616
   Troy, NY 12181-1616

For Customer Service please call: 518-720-8888 ext. 122
Or Email: sdawes@bouchey.com.

bouchey &clarke
BENEFITS, INC.