# **Spending Account Processing**

# **Flexible Spending Account Claim Form**

(Do not fax or mail this instruction page)

This form is used to request reimbursement for health care expenses only. All health care expenses may be first submitted to your health care plan or any other health care coverage that you may have. Please note the following instructions:

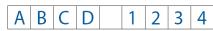
- Use this form to request reimbursement of expenses incurred during the plan year.
- If you are submitting expenses for more than one plan year, you can submit a separate form for each year that you are an eligible participant. Complete all information, and be sure to sign the Self Certification in Section 3.
- Each expense you submit must be properly documented.

**Option 1:** *Go Paperless!* You won't need to complete paper forms anymore. Just submit claims online!

Option 2: Submit your claim using this form.

## Step 1: Complete the form

• Please print in capital letters, with the letters centered in the boxes as shown:



- Complete a separate line for each individual expense.
- Use page 3 if you exceed the number of lines available on page 2.

#### **Step 2: Attach Supporting Documentation**

- See the "Types of Supporting Documentation" box on the right for a description of what is considered acceptable by the IRS.
- Do not send original receipts or supporting documentation.
- Photocopy your receipts or other supporting documentation onto a white, letter-sized sheet of paper.

#### Step 3: Certify

Read the Certification and then sign and date the form.

## Step 4: Submit

109 = Related Travel

110 = Therapy

- **FAX** the form and supporting documentation to **1.866.228.9417**.
- Make sure that you fax the form and supporting documentation together.
   The form should be the first page in the stack of pages that you fax.
- Alternatively, you may also mail your claims to:

**Spending Account Processing PO Box 25173** 

Lehigh Valley, PA 18002-5173

To expedite processing, please send only one claim and supporting documentation per envelope. Sending multiple claim forms in the same envelope may delay processing.

Remember: Keep a copy of the form and all original receipts for your records.

205 = Weight Loss

## Type of Supporting Documentation

- Copy of itemized receipts from your pharmacy or medical/dental/vision provider.
- Copy of Explanation of Benefits (EOB) from your insurance company or health care provider.
- Must show:
  - Date(s) of service(s) or purchase.
  - Type of service or name of product.
  - Amount (paid by you).
  - Name of person or organization providing the service or product.
- Cancelled checks or payment statements are not considered acceptable evidence.
- Prescriptions for over-the-counter (OTC) medications must show the purchase date and the name of the medicine or drug.
- An EOB form is not required for eligible OTC medications.

### **Please Do**

- For multiple expenses on one receipt for the same expense code, use one line to show a total of such expenses (e.g., several over-the-counter items, multiple prescription copays listed on one receipt).
- For expenses that belong to different expense codes or are on different receipts, use one line per expense.
- Use additional copies of Page 3 if your expenses exceed the number of lines available on Pages 2 and 3.
- · Be sure to print legibly and use capital letters.

## **Please Do Not**

- Fill out the form using red or blue ink.
- Highlight receipts or any part of the form.
- Send original receipts.
- Staple copied receipts to the form.
- Write outside of the boxes provided.
- Submit the same claim more than once.
- Fax or mail this Instruction Page.

List of Expense Codes – Sections 2 and 5 of the form need to specify the type of expense using one of the following:

Medical	Medical – OTC	Dental	Vision
101 = Ambulance	111 = Over-the-Counter	301 = Equipment	401 = Equipment
102 = Co-Insurance	Medication	302 = Examination	402 = Examination
103 = Deductible		303 = Orthodontia	403 = Over-the-Counter
104 = Doctor	Medical – Preventative	304 = Over-the-Counter	Medication
105 = Equipment	201 = Immunization	Medication	404 = Pharmacy Prescription
106 = Hospital	202 = Physicals	305 = Pharmacy Prescription	405 = Treatment
107 = Laboratory	203 = Screening	306 = Treatment	
108 = Pharmacy Prescription	204 = Smoking Cessation		

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FAX TO: 1.866.228.9417

or Mail to: Spending Account Processing Center PO Box 25173, Lehigh Valley, PA 18002-5173

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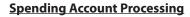
SECTION 1: YOUR INFORMATION (Use only CAPITAL LETTERS)						
PARTICIPANT ID or UMI	EMPLOYER or GRO	UP NAME				
PARTICIPANT LAST NAME	PARTICIPANT FI	RST NAME				
PARTICIPANT EMAIL	DAYTIME	PHONE # (AREA CODE FIRST - NO DASHES)				
OF OTHER WOULD EXPENSES						
SECTION 2: YOUR EXPENSES (Use only CAPITA	· · · · · · · · · · · · · · · · · · ·					
EXPENSE 1 EXPENSE CODE	DATES OF SERVICE FROM (MMDDYY)	AMOUNT				
		\$				
PROVIDER NAME	TO (MMDDYY)	SERVICE PROVIDED TO (NAME & RELATIONSHIP)				
EXPENSE 2	DATES OF SERVICE					
EXPENSE CODE	FROM (MMDDYY)	AMOUNT				
		\$				
PROVIDER NAME	TO (MMDDYY)	SERVICE PROVIDED TO (NAME & RELATIONSHIP)				
SECTION 3: SELF CERTIFICATION						
I certify that all expenses for which reimbur incurred during a period while I was covered u						
or are not reimbursable under any other pla						
sufficiency, accuracy and truthfulness of all						
payment of all related taxes including federal relate to such expense. A copy or electronic	•	•				
deemed as valid as the original. I agree to abi						
form. I fully understand that I alone am respon						
relating to this request and that I am solely lial						
income tax and penalties on amounts paid which relate to such expense. A copy or electronic facsimile of this form and all supporting documentation shall be deemed as valid as the original.						
To the and capporting accumentation onthis be accured as valid as the original.						
EMPLOYEE SIGNATURE:* *Your signature is required in or	der to process your claim for reimbursement	DATE:				
DO NOT OFFIC OPPOSITE						













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SECTION 4: YOUR INFORMATION (ABBREVIATED) (Use only CAPITAL LETTERS)						
PARTICIPANT ID or UMI						
PARTICIPANT LAST NAME	PARTICIPAN	T FIRST NAME				
SECTION 5: YOUR EXPENSES						
EXPENSE 3 EXPENSE CODE	DATES OF SERVICE FROM (MMDDYY)	AMOUNT				
		\$				
PROVIDER NAME	TO (MMDDYY)	SERVICE PROVIDED TO (NAME & RELATIONSHIP)				
EXPENSE 4 EXPENSE CODE	DATES OF SERVICE FROM (MMDDYY)	AMOUNT				
		J \$				
PROVIDER NAME	TO (MMDDYY)	SERVICE PROVIDED TO (NAME & RELATIONSHIP)				
EXPENSE 5 EXPENSE CODE	DATES OF SERVICE FROM (MMDDYY)	AMOUNT				
DDO//DED NAME	TO (MADDINO)	\$ AMAGE PROVIDED TO AMAGE & DELATION OF UP				
PROVIDER NAME	TO (MMDDYY)	SERVICE PROVIDED TO (NAME & RELATIONSHIP)				
EXPENSE 6 EXPENSE CODE	DATES OF SERVICE FROM (MMDDYY)	AMOUNT				
PROVIDER NAME	TO (MMDD)(V)	\$ ALAME & DELATIONOLUD				
PROVIDER NAME	TO (MMDDYY)	SERVICE PROVIDED TO (NAME & RELATIONSHIP)				
EVDENOE 7	DATES OF SERVICE					
EXPENSE 7 EXPENSE CODE	DATES OF SERVICE FROM (MMDDYY)	AMOUNT				
		<b>s</b>				
PROVIDER NAME	TO (MMDDYY)	SERVICE PROVIDED TO (NAME & RELATIONSHIP)				
		`				









