Flexible Spending Accounts Reimbursement Claim Form

Total # Pages Sent: _____

FSA Fax-a-Claim (866) 329-3539 [866-Fax-Flex]

(Please send both Direct Deposit and Check by Mail claims to this fax number. The method of reimbursement for your claim will be determined by the information on file in your account. To view or change your reimbursement information, please log in at www.ProBenefits.com.)

***Employer:** _____

***Participant Name:** _____

Social Sec #: _____ **Daytime Phone:** _____

Mailing Address, if changed: _____

Email Address: _____
Used to send you a confirmation after your claim is processed

Medical/Dental/Vision Care FSA

Indicate date(s) of service, not payment dates

***Date From** _____/_____/_____

***Date To** _____/_____/_____

***Amount $** _____

Dependent Care FSA

Indicate date(s) of service, not payment dates

***Date From** _____/_____/_____

***Date To** _____/_____/_____

***Amount $** _____

You may submit documentation for as many expenses as you like with one claim form; list the earliest and latest dates of service and total amount.
Please submit documentation for all expenses claimed on this form. Per IRS Regulations, all claims must be adjudicated based on provider receipt(s) indicating the following:
- Dates of Service & Amount of Expense
- Type of Service (e.g., Office Visit, Rx, Childcare)
- Name of Provider (e.g., Doctor, Hospital, Childcare Giver)

Credit/Debit Card slips or Cancelled Checks *will not* be accepted as valid documentation.

In Addition, for Dependent Care, per IRS regulations:
- Eligible expenses are for custodial care for children age 12 and under or for dependent, disabled adults.
- IRS requires that the name, address, and tax ID number of your childcare provider be given. If not included on your receipt, please enter below:

Provider Name: _____

SS#/Tax ID#: _____

Address: _____

Comments: _____

Certification: These expenses were incurred (have a date of service) by me and/or my spouse or eligible dependents during the plan year while I have been a covered participant and to the best of my knowledge are reimbursable by the plan. I, the participant, certify that I have not been reimbursed for the above expense(s) and that I will not seek reimbursement under any other plan covering health benefits, such as my spouse's health plan. I understand that any expense reimbursed under this Plan may not be used to claim any income tax deduction or credit. I also understand that privacy regulations prohibit ProBenefits from discussing claims with anyone other than the participant.

***Signature** _____ **Dated** _____

**All items marked are required for processing.*

Log in to check claim status, view account details and more at www.ProBenefits.com

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