Submit Claims By:
Fax: 1-866-643-2245 (toll-free)
1-502-267-2233
Mail: FSAFEDS
PO Box 36880
Louisville, KY 40232

Questions?
1.) Online account information: www.FSAFEDS.com
2.) Automated Account Information: **1-877-FSAFEDS (372-3337)**
3.) Customer Service: **1-877-FSAFEDS (372-3337), (TTY: 1-800-952-0450)**
4.) Email: FSAFEDS@shps.com
Form instructions are located on page 2.

FSA FEDS — Save On Health & Dependent Care

Control # 10779

FSAFEDS Claim Form

Process grace period incurred claims from my ☐ 2006 OR ☐ 2007 account

You must select one of the above boxes. If you don't, your grace period incurred claims will be processed from your 2007 account.

Part I: Employee Information (Please Print) *(If you wish to update your address, please visit the web site at www.FSAFEDS.com)*

Employee Name (Last/First/MI)	**Employee SSN/UserID**
E-mail Address	**Daytime Telephone Number**

Part II: Health Care Expenses

Family Member	Type(s) of Service (Medical, Dental, OTC)	Description of Medicine/Product Service or Supply*	Date(s) of Service	Reimbursement Request Amount
Example: John	OTC	Tylenol	01/04/06	$7.50
1.				
2.				
3.				
4.				
5.				
			Total:	**$** 0.00

*Note: The name of prescription is not required, however, the name of any over-the-counter medicine is required.

Part III: Dependent Care Expenses *(Child care or elder care expenses)*

Reimbursement Request Amount	**Provider's Signature** (*required if receipt is not provided*)	**Provider Tax ID or SSN** (required)
Dates(s) of Service	**Provider's Address**	**Age of Dependent(s) at Time of Service**

Part IV: Employee's Certification for Reimbursement

I affirm that:

- **I HAVE NOT ALREADY BEEN PAID FOR THESE EXPENSES FROM MY FSA and I HAVE NOT REQUESTED AND WILL NOT RECEIVE REIMBURSEMENT FOR THESE EXPENSES FROM ANY OTHER PLAN INCLUDING FEDVIP (Federal Employees Dental and Vision Insurance Program) and FEHB (Federal Employees Health Benefits Program); AND**
- I have submitted the above information in good faith and it is correct to the best of my knowledge;
- The total of any reimbursed dependent care expenses does not exceed my or my spouse's earned income (W-2 Pay) for the year, if either of our annual incomes is less than $5,000.

I understand that:

- Reimbursement is not a guarantee that this payment is tax-free.
- The service(s) for which I am requesting reimbursement must be incurred during my period of coverage, which begins the next January 1 if I enrolled during the Open Season, or the day after my enrollment is accepted by FSAFEDS, whichever is later, and ends no later than March 15 of the following year, unless my coverage ends sooner due to a Qualifying Life Event.
- I have until May 31, 2007 (or April 30 for 2008) to submit my claim for reimbursement of eligible expenses incurred during my period of coverage. If I do not submit claims for reimbursement by that date, I will forfeit any funds remaining in my account(s) in accordance with IRS rules.
- Health care expenses reimbursed through my Health Care Flexible Spending Account cannot be used as a deduction on my personal income tax return.
- Dependent care expenses reimbursed through my Dependent Care Flexible Spending Account (DCFSA) cannot be used as a dependent care credit on my personal tax return. Therefore, reimbursement of dependent care expenses reduces, and may eliminate completely, my ability to claim a dependent care credit on my personal income tax return.
- Dependent care expenses qualify if they are for the care of my children under age 13 or my other dependents who are physically or mentally incapable of caring for themselves and includes anyone I claim on my Federal Income Tax return as a qualified IRS dependent. These expenses must be incurred so that my spouse and I, if married, can work, look for work or my spouse can attend school full-time.
- My household limit for dependent care reimbursement cannot exceed $5,000 per year, including my annual election, any childcare subsidies that I receive, and/or amounts that my spouse has elected through another account.
- The balance in my DCFSA must be at least equal to the expenses submitted with this claim. If the balance in my DCFSA is less, these expenses will be held until the balance in my account is sufficient to pay these expenses.
- I can only be reimbursed for my DCFSA expenses after the date of service has passed.

I authorize release of payment through my Flexible Spending Account(s). I authorize FSAFEDS, or its representatives, to obtain necessary information from all physicians, hospitals, medical service providers, dependent care providers, pharmacists, employers, and all other agencies or organizations (including other insurers) to consider the claim for reimbursement under my Flexible Spending Account(s).

Employee Signature* _____ **Date*** _____

**Your signature and the date are required in order to process your claim for reimbursement.*

FSAFEDS Claim Form Instructions

Please read these instructions before completing the form.

1. Select a plan year at the top of page 1. If you do not select a plan year, all expenses with 2007 dates of service, including all expenses incurred during the grace period (January 1 to March 15, 2007), will be paid from your 2007 account.
2. Complete all areas of Part I "Employee Information."
3. Where applicable, complete Part II "Health Care Expenses" and/or Part III "Dependent Care Expenses."
4. File all eligible health care expenses first under your FEHB or other health care plan and then under any other coverage you may have (such as dental and/or vision insurance) before you request reimbursement from your Flexible Spending Account.
5. This form is to be used only to request reimbursement for:

Health Care Expenses

- Allowable expenses covered, but not fully reimbursed, by any benefit plans. Attach a copy of the plan(s)'s Explanation of Benefits Statement (EOB) as documentation.
- Allowable expenses not covered by any benefit plans. Attach bills or receipts which indicate the name and address of the provider of service and date of purchase.

Supporting Documentation – Health Care Expenses

In addition to the completion of the form, the documentation described under either A or B below must be attached to this form:

A. **Explanation of Benefits Form (EOB):** This is the form you generally receive each time you, or a health care provider, submit medical, dental or vision claims for payment to your health, dental or vision care plan. The EOB will show the amount of expenses paid by the plan and the amount you must pay. For expenses that are partially covered by your (or your dependent's) medical, dental or vision plans, you must attach the EOB. If your FEDVIP dental and/or vision plan does not provide an EOB, please see All Other Expenses below. If you are covered under a HMO/DMO indicate "Co-pay" on Part II under "Type(s) of Service."

B. **All Other Expenses:** Claims for expenses not covered at all by your (or your dependent's) medical, dental or vision plans, will not be processed without acceptable evidence of your expenses. A cancelled check is not considered acceptable evidence. Acceptable evidence includes receipts which contain the following information:
   - Type of service or product provided
   - Date expense was incurred
   - Your name or your dependent's name for whom the service/product was provided, except for over-the-counter medications
   - Person or organization providing the service/product
   - Amount of expense

   If your receipt does not clearly show the name of the product or service provided, you will need to submit copies of the Universal Product Code (UPC) and/or copies of the front of the box/container for over-the-counter (OTC) products and services.

Dependent Care Expenses – In general, the following rules apply to dependent care expenses:
Dependent care expenses qualify if they are for the care of children or other dependents that are physically or mentally incapable of caring for himself or herself. These expenses must be incurred so that you and your spouse, if married, can work, look for work, or your spouse can attend school full-time. However, if either you or your spouse had no earned income for the year, you are not eligible for the Dependent Care FSA. For more information, refer to the dependent care section of the Summary of Benefits and Frequently Asked Questions.

The annual amount of reimbursed dependent care claims cannot exceed:
- Your annual deposit amount up to $5,000 ($2,500 if you and your spouse are filing separate returns), or
- Your annual salary or your spouse's annual salary, if less than $5,000
- Your annual election plus any childcare subsidies cannot total more than $6,000, depending on your tax situation.

- Children must be under age 13.
- Services provided by a child care or elder care center must comply with all state and local laws to be an eligible reimbursement expense.
- FSAFEDS cannot pay for services that have not been rendered.

Supporting Documentation – Dependent Care Expenses

- For allowable Dependent (Day) Care expenses, attach a copy of the bill or signed receipt, or have the provider complete Part III, "Dependent Care Expenses" on the reverse side.
- Requests **will not be processed** without the Tax ID Number or Social Security Number for all providers. You must provide this number each time you submit a claim.
- List placement fee expenses separately under the "Reimbursement Request Amount" field. Include a copy of the receipt for those expenses. If your claim includes other dependent care expenses, simply list the pro-rated Placement Fee amount under or next to the other expense total.

6. Read the Employee's Certification for Reimbursement Statement, then sign and date the form where indicated.
7. FSAFEDS has a minimum reimbursement threshold of $25.00. If your claim does not total $25.00, it will be processed and you will receive a reimbursement statement, but your payment will be pended until you submit another claim and reach the $25.00 aggregate amount, or until the end of the quarter, whichever comes first.
8. Submit this form and supporting documentation to the address listed at the top of the claim form or fax to 1-866-643-2245 (toll-free). If you are sending from outside the United States, please fax to 1-502-267-2233.