# FLEXIBLE SPENDING ACCOUNT (FSA) REIMBURSEMENT CLAIM FORM

There are **three ways** to submit eligible expenses for reimbursement through your FSA.

1. Submit a claim **ONLINE** at **www.myFlexDollars.com** and upload your receipts.
2. Complete this claim form and **FAX** it along with your receipts to the Vantagen FSA Unit at **1-866-406-0946**.
3. Complete this claim form and **MAIL** it along with your receipts to the Vantagen FSA Unit at 1200 Abington Executive Park, Clarks Summit, PA 18411.

For general questions and account information, visit **www.myFlexDollars.com**. To speak with a customer service representative, call the Employee Benefits Center at **1-800-307-0230**.

## SECTION 1 – EMPLOYEE PROFILE (Please Print)

**COMPANY NAME:** _____ **DAYTIME PHONE #:** _____

**SSN (Last Four Digits Only):** XXX – XX – _____ **EVENING PHONE #:** _____

**EMPLOYEE NAME:** _____ **EMAIL ADDRESS:** _____

**MAILING ADDRESS:** _____ **LOCATION:** _____

_____

## DESCRIPTION OF EXPENSES – See Reverse Side for more detailed instructions.

## SECTION 2 – HEALTH CARE EXPENSES (Please provide the requested information for each expense on a separate line.)

| Dates of Service (MM/DD/YY) | | Patient Name* | Relationship to Employee | Name of Provider/Pharmacy* | Description of Service/Medicine/Drug* | Reimbursement Requested* |
|---|---|---|---|---|---|---|
| Start Date | End Date | | | | | |
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***Required Information** **Total Reimbursement Requested*** 

## SECTION 3 – DEPENDENT CARE EXPENSES (Please provide the requested information for each expense on a separate line.)

| Dates of Service (MM/DD/YY) | | Dependent Name* | Relationship to Employee | Name of Provider* | Type of Service* | Tax ID # or SSN | Reimbursement Requested* |
|---|---|---|---|---|---|---|---|
| Start Date | End Date | | | | | | |
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***Required Information** **Total Reimbursement Requested*** 

**Provider Signature** **Date**

**Direct Provider Payment**
To have a claim paid directly to a provider, you will need to submit your claim online at **www.myFlexDollars.com**.

## SECTION 4 – AUTHORIZATION

I certify that the medical and or dependent care expenses submitted for reimbursement were rendered to me or an eligible member of my family during the period I was a participant in the Health Care and or Dependent Care Flexible Spending Account. I further certify that the medical care expenses are not eligible to be paid by the health care coverage provided through my employer or from any other source, such as my spouse's employer's health plan. I understand that I have the responsibility for any tax reporting or other requirements with respect to reimbursed expenses. I also understand that to the extent medical and or dependent care expenses are reimbursed under the Health and or Dependent Care Flexible Spending Account, they may not be claimed as expenses on my or my spouse's tax return. I also understand that the charges for which I am submitting reimbursement are eligible charges in accordance with IRS guidelines and IRS Publication 502. I certify that all over the counter medicine or drug expenses were incurred for medical care. I agree that I am responsible for any and all bank, savings, or checking account charges that I incur. I agree to indemnify and hold harmless Vantagen from any responsibility relative to my credit status. I have received and read all printed material describing this program and all administrative materials defining the operation of this plan. I certify that I am responsible for compliance with all applicable administrative processes, tax regulations and documentation. I will retain a copy of this form and all original receipts for my records.

**Signature** **Date**

# INSTRUCTIONS AND HELPFUL HINTS

## GENERAL INFORMATION

The Employee Benefits Center must receive your claim(s) and supporting documentation by Noon (EST) on each processing deadline (call 1-800-307-0230 if you are unsure of your company's processing deadline). If your submitted claims are authorized, you will then receive reimbursement. Some claim reimbursements may be delayed due to coordination of benefits requirements.

## SECTION 1 – EMPLOYEE PROFILE

- ☑ Please fill in **all** of the requested information.
- ☑ Remember to print or type in your information so we can process your claim quickly and accurately.

## SECTION 2 – HEALTH CARE EXPENSES

- ☑ Please fill in **all** of the fields marked with an asterisk (*) as that indicates information that is required and must be filled in for your claim to be processed.
- ☑ Provide a copy of the Explanation of Benefits (EOB) from your insurance company for qualified expenses (if available).
- ☑ If you are attaching a copy of an itemized statement as proof for a qualified expense, the itemized statement must contain the following information: **(1)** the name and address of the provider, **(2)** patient name, **(3)** date of service (date service was provided, not the date service was paid for), **(4)** description of service provided, and **(5)** itemized charges.
- ☑ If you are submitting a claim for a prescription drug, **the prescription number (RX #) must be on the receipt** that you submit with your claim form.
- ☑ Cancelled checks and credit card receipts **ARE NOT** considered acceptable documentation of expenses listed on this form.
- ☑ For qualified over-the-counter expenses, you must submit evidence of the purchase date and the specific medicine and/or drug name. **Vitamins, supplements and hygienic products are not qualified expenses and cannot be reimbursed through your FSA.**
- ☑ For all other expenses you must attach itemized receipts.
- ☑ Only submit copies of receipts, itemized statements, etc., since this documentation **will not** be returned to you.

## SECTION 3 – DEPENDENT CARE EXPENSES

- ☑ Please fill in **all** of the fields marked with an asterisk (*) as that indicates information that is required and must be filled in for your claim to be processed.
- ☑ The service(s) you are submitting a claim for **must have occurred. We cannot reimburse payments for future dates of service.**
- ☑ Provide a copy of a receipt or bill from the provider of the service with this form.
- ☑ The bill/receipt submitted along with this form must include the following information: **(1)** the name of the provider, **(2)** the address of the provider, and **(3)** the provider's tax identification number or Social Security Number if your provider does not have a tax identification number.
- ☑ If there is not enough money in your Dependent Care FSA to pay the entire amount of the claim you submit, the claim will be paid up to the amount currently available in your account. You **do not** need to resubmit this claim again to receive full reimbursement. As more money accumulates in your account, you will automatically be reimbursed up to the full amount of the claim.

## SECTION 4 – AUTHORIZATION SECTION

- ☑ Read the Authorization Section carefully.
- ☑ **Make sure to sign and date this form before submitting it for reimbursement.**

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**Don't forget to check out MyFlexDollars.com – your one-stop FSA resource. Log in today to view your account balance, check the status of a claim, file a claim, and more!**