FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT REQUEST

630-286-4660 – Fax

fsa@pbaclaims.com - Email

Mail Claims to:
Professional Benefit Administrators, Inc.
P.O. Box 4687
Oak Brook, IL 60522
Phone: (800) 435-5694

☐ Check this box if your address has changed

Name (Last & First Name)				ID #
Address	City	State	Zip Code	Telephone No.
Name of Employer				Email Address

Health Care / Medical Expenses

Name of Provider	Name of Claimant	Date of Service	Covered Under Health Plan Y / N	Total Expense Amount	Total Claimant Responsibility
					$
					$
					$
					$
					$

TOTAL

Dependent Care Expenses – Child Care/Elder Day Care

Dependent's Full Name	Date of Service From	To	Provider of Service ***	Federal Tax ID	Reimbursement Request Amount
					$
					$
					$
					$

*** You will be required to provide the name, address and tax identification or Social Security number of the Service Provider to the IRS when you file your annual income tax return.

TOTAL

PARTICIPANT'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my FSA were incurred by me (and/or my spouse and/or dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my FSA. I (or we) will not use the expenses reimbursed through the FSA program as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive, files a statement of claim containing false, incomplete, or misleading information may be guilty of a criminal act punishable under law. SIGNATURE IS REQUIRED FOR REIMBURSEMENT.

Signature _____ **Date** _____

SIGN UP FOR DIRECT DEPOSIT TO RECEIVE YOUR FUNDS FASTER.

Bank Name _____

Checking _____ **Savings** _____ **Routing number**_____ **Account Number**_____

FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT INSTRUCTIONS

Employee Instructions

1. Always complete all areas of “Employee Information”, “Health Care Expenses” and/or “Dependent Care Expenses”.
2. If you have coverage under one or more benefit plans, mark “Y” in the “Covered Under Health Plan” section and attach copies of each Plan’s Explanation of Benefits (EOB) in support of your request for reimbursement of out-of-pocket expenses (deductibles, coinsurance, non-covered items, etc.). Your insurance Plan and any other Plan (e.g. your spouse’s or an individual Plan) must pay before you request an FSA reimbursement.
3. For Dependent Care Expenses, attach a copy of the itemized bill or statement to this form and complete the Dependent Care Expenses section.
4. Sign and date the bottom of the FSA Reimbursement Request form after you read the "Certification for Reimbursement".
5. Fax the Reimbursement Request to (630) 286-4660, mail it to the address below or scan/email to:

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6. To sign up for Direct Deposit and receive your reimbursement faster, indicate if the bank account is a checking or savings account and include the bank routing number and account number. All new information is pre-noted to ensure account accuracy.

The following supporting documentation must be attached to a FSA Reimbursement Request form:
It is **your** responsibility to provide supporting documentation for this claim in the event of an IRS AUDIT.

Medical Expenses

- Expenses covered by your Group Insurance Plan(s) **MUST BE SUBMITTED** under that Plan first. Attach a photocopy of the Explanation of Benefits (EOB) statement to claim the amounts not paid by your Group Plan(s).
- If you and your spouse are both covered by Group Health Plan(s), the **EXPENSES MUST BE SUBMITTED** to both Plans first. Attach a photocopy of both EOBs to claim any amount not paid by the Plans.
- For expenses where there is no coverage, always send a copy of the itemized bills. We cannot accept credit card receipts, register receipts or balance due statements that do not itemize the expense.

Who can file a Reimbursement Request

- Only employees participating in the Flexible Spending Account Plan can file a Reimbursement Request Form.
- Employees can file a claim form during the Plan year and for a certain period after the Plan year as described in the Summary Plan Description.
- Terminated employees can file a claim form for the Plan year as described in the Summary Plan Description.

What Health Care Expenses Can Be Claimed

- Only Expenses incurred during the Plan year and grace period (when applicable) can be claimed for reimbursement.
- Terminated employees can claim expenses incurred prior to the date of termination and for the period of time allowed in the Summary Plan Description, unless you continue the Flex Plan under COBRA for the balance of the year.
- Allowable expenses are the same as those allowed for income tax deduction purposes as outlined by the IRS.

Dependent Care Expenses

- If your dependent care provider is a formal day care center, complete the information on the claim form, and send a photocopy of the billing from the dependent care provider. If your dependent care provider is not a formal business that uses a standard billing, then you must submit a paid receipt showing the amount and dates of service or a photocopy of your check.

Qualifying Dependent Care Expenses

- Employment-related expenses to a dependent care provider or center for a dependent under the age of 13.
- Expenses paid for care of dependents who are physically or mentally incapable of caring for themselves.
- The annual amount submitted for reimbursement cannot exceed the earned income of the lower-paid spouse.
- The payment cannot be made to a person who is claimed as a dependent by the employee.

Direct Deposit

- Direct Deposit allows you to have your Medical and Dependent Care reimbursements electronically deposited into your bank account and eliminates the hassle of mail delays or late deposits.
- Once enrolled for Direct Deposit all future reimbursements will be automatically direct deposited to the account on file.