Flexible Spending Account Claim Form

Today's Date: _____/_____/_____ **# of pages:** _____ **Plan year beginning for:** 20___

❑ New Claim ❑ Resubmission of claim ❑ Response to claim denial

Employer Name/Division Name:	Employee Name:	
Address: ☐ **Please check if change of address**		
Social Security Number:	E-mail Address:	Home Phone: Work Phone:

Please note: Not all these accounts may apply to your group

❑ **Medical Expense Reimbursement Account** **Total Amount Requested** _____

- Enclose insurance company statement or itemized bill from provider showing date of service, services rendered, provider of service, amount paid and, if applicable, amount covered by insurance.
- Prescription claims **MUST** include the R_X number pharmacy receipt, not cash register receipt.
- Allowable reimbursement for mileage expenses

❑ **Dependent Care Reimbursement Account** **Total Amount Requested** _____
Must include provider Tax ID Number

❑ **Individual Premium Reimbursement Account** **Total Amount Requested** _____
Please attach proof that employee owns policy

❑ **Adoption Assistance Reimbursement Account** **Total Amount Requested** _____

❑ **Parking Reimbursement Account** **Total Amount Requested** _____

❑ **Transportation Reimbursement Account** **Total Amount Requested** _____

❑ **105(h) Health Reimbursement Account** **Total Amount Requested** _____

Sign up for direct deposit TODAY!

Minimum Reimbursement for manual claims - $25

Date of Service	**E**mployee, **S**pouse or **D**ependent	Amount Requested	Type of Service (R_X copay, dental, etc.)	Service Provider/ R_X # (**MUST** be provided)
1.				
2.				
3.				
4.				
5.				

Please note the following requirements for claims submission:

* Please number each receipt according to its order of appearance on this form.
* IRS guidelines do **NOT** consider cancelled checks as valid documentation.
* Previous balances are **NOT** acceptable.
* All reimbursements will be made payable to the employee.

To the best of my knowledge and belief, my statements in this reimbursement voucher are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed on this or any other benefit plan and WILL NOT BE CLAIMED AS AN INCOME TAX DEDUCTION. I authorize my Flexible Compensation account be reduced by the amount requested.

EMPLOYEE'S SIGNATURE_____DATE_____

For faster service, fax claims to: (716) 855-7105 or (877) 855-7105

Or mail to: Flex Department, 17 Court Street, Suite 500, Buffalo, NY 14202-3204

Visit our website to access account information at www.padmin.com

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