MEDICAL EXPENSE CLAIM FORM

Company:	

Employee Name:	Last First MI	**SS#**	**XXX-XX-**
Address:	Street City State ZIP	**PHONE**	
Email Address:			

☐ **Please check if this is a new address**

Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this claim.

Date of Service MM/DD/YY	Patient Name	Patient's SS#	Relationship	Name of Provider	Description of Service	Claim Amount
		XXX-XX-				$
		XXX-XX-				$
		XXX-XX-				$
		XXX-XX-				$
		XXX-XX-				$
		XXX-XX-				$
		XXX-XX-				$
		XXX-XX-				$
		XXX-XX-				$
		XXX-XX-				$
		XXX-XX-				$
		XXX-XX-				$
		XXX-XX-				$
					Total:	$ 0.00

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I hereby authorize release of payment through my Flexible Spending Account(s). I hereby authorize your company 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 (this includes other insurers) to consider the claim for reimbursement under my Flexible Spending Account.

To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses and not for cosmetic purposes incurred during the plan year for myself and/or my legal dependent(s). I certify that these expenses have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement or claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ **Date:** _____ /_____ /_____

FOR FASTEST REIMBURSEMENT FAX TO 866-872-2125
EMAIL TO: INFO@USBAFLEX.COM
OR MAIL TO: USBAFLEX
860 EAST 9085 SOUTH
SANDY, UTAH 84094

FORM 1001/4-11

Account Rules and Claim Filing Instructions

Claim Filing Instructions

1. To be reimbursed, complete all information on the claim form for each expense being requested.
2. Attach all appropriate documentation to the reimbursement form. Documentation must indicate the provider's name and contact information, the date of service (not the date of payment), a description of services rendered, and the employee's portion of the expense. Documentation can be submitted in the form of:
    A. Itemized bill/ledger from the service provider
    B. Explanation of Benefits Form from Insurance Carriers.
    C. Register receipt for approved over-the-counter items/medicines or prescriptions. All medications must have a physicians' prescription or Rx number.

PLEASE DO NOT SEND COPIES OF CHECKS OR BANK STATEMENTS AS RECEIPTS. THEY DO NOT PROVIDE ALL NECESSARY INFORMATION.

3. Orthodontia expenses must be accompanied by a contract or letter from the provider apportioning expenses to be incurred during the current plan year. Orthodontic contracts must be submitted during each plan year where reimbursements will be made. You can find an orthodontic contractual letter online at www.USBAFLEX.com.
4. **Sign and date** the reimbursement request claim form, certifying that the expenses are eligible and duplicate reimbursements will not be sought elsewhere (including Federal income taxes).
5. **Make a photocopy of the entire claim for your records.** Submitted documentation will not be returned.
6. Submit the Claim with attached receipts according to the procedures provided.

Rules for Medical Accounts

1. A claim cannot be submitted unless you are participating in the Cafeteria Plan.
1. Reimbursements will only be made for eligible expenses occurring during the coverage period in which your contributions are made.
2. A claim can be submitted at any time during the plan year and for a specified period after the plan year as described in the Summary Plan Description.
3. If you terminate employment, submit a claim for a specified period after the date of termination if so stated in the Summary Plan Description as long as the service occurred before your date of termination.
4. IRS rules stipulate that any money left in the account(s) after all reimbursements for the plan year have been processed cannot be carried forward or returned. Money in one account cannot be used for expenses incurred in another account. For instance, any unused amounts left in the medical account cannot be used to reimburse dependent care expenses.
5. Payment cannot be received from any other source for expenses reimbursed by claim, and you certify that you are not eligible to bill any other source for the reimbursed expenses.
6. Expenses you have received reimbursement for cannot be claimed for income tax purposes.
7. The total annual election for eligible medical expenses (less any previous reimbursements paid) is available when requested for covered expenses.

Internal Revenue Service Publication 502 lists the eligible tax-free expenses. An Eligible expense means any item for which you could have claimed a medical expense deduction on an itemized Federal income tax return (except insurance premiums, long-term care and other similar charges) and is not eligible under your medical or any other source. You or your dependents while participating in the plan must incur the expenses.