FSAFEDS Appeals Form

Information

For your reference, copies of documents and information related to the denied claim are available online by accessing the denied claim from your participant portal (log in at www.FSAFEDS.gov).
For more information on the appeals process you may visit our File an Appeal page https://www.FSAFEDS.gov/file/appeal.

Instructions

1. Complete the Appeal Form
2. **Attach any documents, records, or other information that relates to the appeal.**
3. **Mail (recommended) or fax the completed appeal form and any additional information to:**
   Mail: FSAFEDS Program - Appeals
   P.O. Box 14800
   Lexington, KY 40512-4800
   Toll-free Fax: 866-852-2599

Account Holder Information

Agency name	Last 4 of SSN *(Please do not include your full SSN)*		
Last name	First name		M.I.
Street address	City	State	ZIP
Email address	**Daytime phone** ( )		

Appeal Information

Provider	Appeal submission date	Actual date(s) of service Start date:____/____/____ End date:____/____/____
Amount requested	Disputed amount	
Claim Form number	Type of account (Health Care FSA, Dependent Care FSA)	

Explanation of Appeal

Use the space provided to explain your concern. Include names, dates when possible, any additional supporting documentation, and any other applicable information that clearly supports your appeal. (If more room is needed, please attach an additional page.) Attach any documentation necessary to support your claim. **Send only copies of receipts.** Keep original receipts for your records.

Appeal Holder Signature

Account holder signature	Date

If you have questions, our Benefits Counselors are available Monday through Friday from 9 a.m. to 9 p.m. Eastern Time, excluding holidays.
Visit www.FSAFEDS.gov or contact us toll-free at 877-FSAFEDS (877-372-3337), TTY: 866-353-8058, International: +1 650-577-5294.