Submitting Claims Quick Reference Guide

Under the FSAFEDS Program, you must submit a completed FSAFEDS Health Care FSA claim form or FSAFEDS Dependent Care FSA claim form along with itemized receipts or other appropriate documentation, as described in this guide.

Keep in mind that expenses are eligible on the actual date of service, not the date of payment. This means you incur the expense when the service is provided. Orthodontic treatment is an exception to this rule, and FSAFEDS will reimburse pre-paid orthodontia expenses regardless of the date of service (see Orthodontia Quick Reference Guide).

Health Care FSA Claims

There are hundreds of eligible health care, dental, and vision expenses that can be reimbursed under your Health Care FSA. All eligible expenses must meet IRS criteria as a qualified medical expense. For complete listings of eligible medical expenses, please see Eligible Expenses at www.FSAFEDS.gov or review IRS Publication 502. Please note: Some expenses listed in IRS Publication 502 for income tax purposes are not necessarily eligible under the health care FSA. For example, insurance premiums are listed as an eligible medical expense in IRS Publication 502, but are not eligible under a health care FSA. Also see IRS Publication 969 for helpful information on Health Savings Accounts (HSAs) and other tax-favored health plans.

Health Care Expenses	Examples	Supporting Documentation
Expenses covered, but not reimbursed (in full or in part) by: • Federal Employees Health Benefits (FEHB) plan • Federal Employees Dental and Vision Program • Another health insurance plan • Other supplemental insurance	• Co-pays for office visits • Co-insurance • Services that apply toward your deductible • Office visits to out-of-network providers	• An Explanation of Benefits (EOB) statement (original or copy) from your FEHB or other insurance plan • An itemized receipt from the provider of the service or item

Health Care Expenses	Examples	Supporting Documentation
Eligible expenses not covered by your FEHB or any other health plan, or supplemental insurance, such as FEDVIP dental insurance and/or FEDVIP vision insurance.	• Certain infertility treatments • Many alternative therapies • Potentially eligible services requiring a Letter of Medical Necessity (LMN)	• Itemized bills or receipts that include: - **Patient's name** - **Provider's name** - **Date(s) of service** - **Type of service or product** - **Cost** • If applicable, a Letter of Medical Necessity (LMN) - **After length of treatment noted on the LMN expires, a new LMN is required**
Eligible expenses not submitted to your FEHB or any other health plan, or supplemental insurance, such as FEDVIP dental insurance and/or FEDVIP vision insurance.	• Mental health services that are covered under your health plan, but you choose to pay for out-of-pocket without submitting to your FEHB plan • Prescription drugs that you choose to pay out-of-pocket without submitting to your FEHB plan • Potentially eligible services requiring a Letter of Medical Necessity (LMN)	Same information required above
Over-the-counter (OTC) medicines and products	• OTC medicines, such as aspirin, pain relievers, allergy medicine, etc. • OTC items and supplies, such as first aid kits, bandages, blood pressure monitors, etc. • See Eligible Expenses at FSAFEDS.gov • Potentially eligible services requiring a Letter of Medical Necessity (LMN)	• An itemized receipt including: - **Vendor name** - **Date of purchase** - **Product name** - **Cost**

*If your FEHB or other insurance plan's Explanation of Benefits (EOB) does not clearly indicate the service rendered, FSAFEDS may ask you for additional information, including a Letter of Medical Necessity from your health care provider.

Paperless Reimbursement

If you participate in paperless reimbursement (PR), claims that are processed by your participating FEHB plan and/or FEDVIP plan are automatically forwarded to FSAFEDS for reimbursement of your out-of-pocket costs. If you participate in PR, you should NOT submit paper claims for expenses that are coming across automatically from your FEHB and/or FEDVIP plan.

- To learn more about PR or to find out if your FEHB and/or FEDVIP plan participates in the program, please refer to the Paperless Reimbursement Overview Quick Reference Guide.
- **Important:** If you participate in PR with your FEHB plan and are enrolled in a FEDVIP plan that does not participate in PR, some or all of your dental expenses and/or vision expenses may be covered by FEDVIP. Therefore, we cannot automatically process eligible dental claims and/or vision claims from your FEHB plan using PR. Instead, we will email you a reimbursement statement to let you know to submit a manual claim along with your FEDVIP EOB or itemized statement from your dental and/or vision provider to FSAFEDS for reimbursement of your eligible expense(s). If you have used all the benefits available to you through your FEDVIP coverage, you can immediately complete the claim form and submit it to FSAFEDS with the appropriate documentation that supports your remaining out-of-pocket expense.

Dependent Care FSA Claims

All of your eligible dependent care expenses must be incurred so that you and your spouse, if you are married, can work, look for work*, or attend school full-time. Eligible dependent care expenses include:

- Child care for your children under age 13,
- Day care for your spouse or your children (of any age) who are physically or mentally incapable of self-care who you claim on your Federal Income Tax return as a qualified dependent,
- Elder care for adults who you claim on your Federal Income Tax return as a qualified dependent

A Dependent Care FSA works differently than a Health Care FSA. You can only be reimbursed up to the amount that is currently in your FSAFEDS account at the time you submit a dependent care claim. Eligible expenses that you claim in excess of your current account balance will be held until additional funds are contributed to your FSA. You don't have to resubmit those claims. Once your contributions are posted to your DCFSA, your funds will release automatically.

Please note: Expenses cannot be reimbursed **before** the care has actually been provided for your dependent, even if your provider requires payment in advance. If you submit a claim for expenses to be incurred in the future, it will be denied and you will have to resubmit it after the services are rendered.

Example: On Monday, March 1, you enroll your son in a daycare that requires pre-payment each month. That day, you pay $800 for the month of March and immediately submit your claim form. FSAFEDS will process your claim, but can only reimburse you for $27 up to the date we receive your claim (March 1, in this case). Any expenses incurred after the date of receipt will be denied and you must resubmit for payment.

While we can't reimburse your expenses in advance of when the care or service was rendered, FSAFEDS does offer you the opportunity to submit multiple claims to recoup your out-of-pocket expense more timely. For childcare that you must pre-pay a month in advance, we suggest you complete and submit a FSAFEDS Dependent Care FSA claim form once a week. Using the example above, you would fax your first claim to FSAFEDS on March 5 requesting $200 for Week 1. You can then submit the additional charges for reimbursement each week as the services are rendered, thus minimizing your out-of-pocket expense.

* If either you or your spouse had no earned income for the year, you are not eligible for the Dependent Care FSA. For more information, see the FAQs at www.FSAFEDS.gov.

Dependent Care Expenses – Supporting Documentation

You can either:

- Attach a copy of your dependent care bill or signed receipt to your claim form, OR
- Have your provider sign the Affidavit section of the claim form

How Can I Submit My Claim Form?

FSAFEDS App: Log in using the same username and password as your online account.

Online: Log in to your online account at www.FSAFEDS.gov and follow the step-by-step instructions.

Toll-free Fax: 866-643-2245

Mail: FSAFEDS Program – Claims, P.O. Box 14127, Lexington, KY 40512-4127

Claim Review and Appeal Process

You have the right to submit an appeal of a claim for benefits that we have denied.

- If you disagree with our decision or need additional information about your claim denial, please contact an FSAFEDS Benefits Counselor within 30 calendar days from the date of the decision to request a more detailed explanation. You may contact an FSAFEDS Benefits Counselor toll-free at 877-FSAFEDS (372-3337), TTY: 866-353-8058, Monday through Friday from 9 a.m. until 9 p.m., Eastern Time.
- If you do not agree with the explanation provided by FSAFEDS, you have the right to formally appeal a claim for benefits that has been denied by writing to FSAFEDS and requesting reconsideration. You can submit formal appeals with supporting documentation via fax or mail. For more information, please read the Appeal Process Quick Reference Guide.

If you have questions, visit the FSAFEDS website at www.FSAFEDS.gov. Or you may contact an FSAFEDS Benefits Counselor toll-free at 877-FSAFEDS (372-3337), TTY: 866-353-8058, Monday through Friday from 9 a.m. until 9 p.m., Eastern Time.

Additional Details

- Most claims are processed within five business days after they are received and verified, as long as they contain all of the required information discussed above.
- Processing may be delayed if supporting documentation or a Letter of Medical Necessity form is not included with your claim.
- We will reprocess your claim after we receive the missing documentation.
- We will also revise your claim received date to reflect the date we receive the missing documentation. Your claim will be processed within five business days of that revised date. Payments are sent shortly thereafter.
- If your claim does not total $5.00, you will not receive reimbursement until you submit another claim and reach the $5.00 minimum.
- Remember, you will not receive reimbursement for dependent care claims that exceed the current contributions in your DCFSA on the date your claim is processed. Your reimbursement will be held until additional funds are deposited.
- You will receive reimbursement for health care claims even if the current contributions in your account is less than the total claim amount.
- The total amount you can be reimbursed for any account cannot exceed your total annual election for that account.