HEALTH CARE FSA

How to File a Claim for Approval

Claim Filing Options:

- **File claim online:** Log in to your account at **www.FSAFEDS.gov** to submit your claim electronically with uploaded documentation.
- **File claim via fax or mail:** Claim details may be entered online and a completed form may be printed and faxed or mailed with documentation. **Toll-free Fax:** 866-643-22 45, **US Mail:** FSAFEDS Program – Claims, P .O. Box 14127, Lexington, KY 40512-4127

If you have questions: Visit the FSAFEDS website at **www.FSAFEDS.gov** or 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.

Whose expenses are eligible for reimbursement?

- An eligible dependent is defined as a spouse, qualifying child, or qualifying relative.
- A qualifying child is defined as a tax dependent child up to age 26 or any age if permanently disabled.
- A qualifying relative is someone who resides with you for more than half of the year.
- Qualifying children and relatives must not provide more than half of his/her own support.
- An eligible dependent is defined as a spouse, qualifying child, or qualifying relative.

Eligible Expense: For a list of eligible expenses specific to your plan, go to **www.FSAFEDS.gov** and select "Eligible Expense."	**Documentation Requirements:** Proof of services from a third party, such as Explanation of Benefits (EOBs) from insurance company or provider of service.
• A letter of medical necessity is required for any expense listed as "Yes (Letter)" on the eligible expense list to establish medical necessity. • Orthodontia Expense: for more information refer to the Orthodontia Quick Reference Guide.	Explanation of Benefits (EOBs) are recommended, especially if your insurance covered a portion of the expense. The service documentation will need to include: • Provider Name • Service Dates (not payment date) • Patient Name • Type of Service • Out-of-Pocket Cost or Your provider may sign the form confirming the date of services, charges and other service or product information in lieu of providing separate documentation or other proof of service.

Instructions to fill out this form:

Complete ALL account holder information.

Use your documentation to complete each section of the form, including the following:

1. **Provider Name**
2. **Service Date(s)**
3. **Patient Name and Relationship to Account Holder**
4. **Type of Service**
5. **Patient Responsibility**

Optional:

Your provider signature can replace the need for separate documentation or other proof of service.

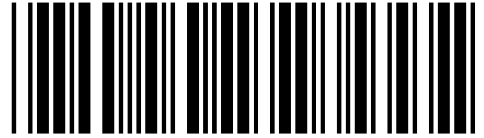
ACCOUNT HOLDER:
S M I T H — Last Name; J O H N — First Name
Employer
5 4 2 — ID Code*; 1 0 0 — Month/Day of Birth; ZIP Code
*ID Code is the last 4 digits of your Social Security number.

PROVIDER NAME	SERVICE DATES (Start and End Dates) (MM/DD/YY)	PATIENT NAME, RELATIONSHIP TO ACCOUNT HOLDER AND TYPE OF SERVICE	OUT-OF-POCKET COST
Mercy Hospital	010319 010319	Patient Name: John Smith; Relationship: Self; Type of Service: Co-payment	25.00
Mercy Pharmacy	010419 010419	Patient Name: Mary Smith; Relationship: Spouse; Type of Service: Rx	10.70

Claim Submission	**Claim Status Tips**
• Ensure that the documentation is legible. • Do not highlight your documentation; it can cause documentation to be illegible. • Cancelled or copies of checks and credit card receipts are not acceptable forms of documentation: they do not include the required information (listed above) to approve your expense. • All documentation must be submitted in English (foreign receipts should be translated to English and US dollars) • Cover page is not recommended when faxing claim. • Original documentation should be kept for your record, send a photocopy of your documentation if submitting via US Mail. • Submit only claims you wish to be reimbursed from your own account.	• Please allow up to 5 business days from receipt of your claim for processing. • You will be notified of the status of your claim based on your www.FSAFEDS.gov "Profile" preferences. • To update your "Profile" preferences, please log into your account at www.FSAFEDS.gov and select "Profile" in the upper right corner of the screen.

HEALTH CARE FSA

Pay Me Back Claim Form



- **File claim online:** Join the growing majority of participants who submit their claim online for faster service. Log in to your account at **www.FSAFEDS.gov** to file your claim electronically and upload your documentation.
- **File claim via fax or mail:** Claim forms may also be filed either via fax or US Mail and sent to the following locations: **Toll-free Fax:** 866-643-2245, **US Mail: FSAFEDS Program – Claims, P.O. Box 14127, Lexington, KY 40512-4127**
- **If you have questions:** Visit the FSAFEDS website at **www.FSAFEDS.gov** or 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.

ACCOUNT HOLDER:

Last Name

First Name

Employer

ID Code*

Month/Day of Birth

ZIP Code

* ID Code is the last 4 digits of your Social Security number.

PROVIDER NAME	SERVICE DATES (Start and End Dates) (MM/DD/YY)	PATIENT NAME, RELATIONSHIP TO ACCOUNT HOLDER AND TYPE OF SERVICE	OUT-OF-POCKET COST
Signature of Provider: (Replaces the need for other proof of service.)		**Patient Name:** ____ **Relationship to Account Holder:** ☐ Self ☐ Spouse ☐ Qualifying Child ☐ Qualifying Relative ☐ Other: ____ **Type of Service:** ☐ Rx ☐ Lab ☐ Dental ☐ Vision ☐ Psych/Therapy ☐ Hospital ☐ Ortho ☐ X-Ray ☐ Chiro ☐ OTC ☐ Co-payment ☐ Mileage ☐ ____	
Signature of Provider: (Replaces the need for other proof of service.)		**Patient Name:** ____ **Relationship to Account Holder:** ☐ Self ☐ Spouse ☐ Qualifying Child ☐ Qualifying Relative ☐ Other: ____ **Type of Service:** ☐ Rx ☐ Lab ☐ Dental ☐ Vision ☐ Psych/Therapy ☐ Hospital ☐ Ortho ☐ X-Ray ☐ Chiro ☐ OTC ☐ Co-payment ☐ Mileage ☐ ____	
Signature of Provider: (Replaces the need for other proof of service.)		**Patient Name:** ____ **Relationship to Account Holder:** ☐ Self ☐ Spouse ☐ Qualifying Child ☐ Qualifying Relative ☐ Other: ____ **Type of Service:** ☐ Rx ☐ Lab ☐ Dental ☐ Vision ☐ Psych/Therapy ☐ Hospital ☐ Ortho ☐ X-Ray ☐ Chiro ☐ OTC ☐ Co-payment ☐ Mileage ☐ ____	
Signature of Provider: (Replaces the need for other proof of service.)		**Patient Name:** ____ **Relationship to Account Holder:** ☐ Self ☐ Spouse ☐ Qualifying Child ☐ Qualifying Relative ☐ Other: ____ **Type of Service:** ☐ Rx ☐ Lab ☐ Dental ☐ Vision ☐ Psych/Therapy ☐ Hospital ☐ Ortho ☐ X-Ray ☐ Chiro ☐ OTC ☐ Co-payment ☐ Mileage ☐ ____	

More expenses? Please complete another form.

CLAIM FORM TOTAL:

CERTIFICATION AND AUTHORIZATION: I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible deductible expenses incurred by myself or an eligible dependent while I was a participant in the plan. (Patient & Relationship is assumed to be Self unless otherwise indicated.) I have already received these products and services and confirm that by requesting reimbursement here that I have not and will not seek reimbursement of this expense from any other plan or party. If I am covered under more than one health care account, reimbursement will be made according to the payment order determined by those plans and as stated on the website. Use of this service indicates my acceptance of the User Agreement at www.FSAFEDS.gov (available upon registration; enter username and password or click on New to the Site? link).