PO Box 350
Conshohocken PA 19428

Health Care Flexible Spending Account Claim Form

Employee Information

Employer Name			
Employee Name	Date of Birth	Employee ID Number	
Street Address	City	State	Zip Code

List of Reimbursable Expenses
Attach corresponding itemized bills, receipts, or insurance carrier's Explanation of Benefits

Patient Name	Description of Expense	Date of Service	Provider of Service	Amount of Expense
			Total Expenses:	

Authorization

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 incurred during the applicable plan year for myself and/or my legal tax dependent(s). Please note that domestic partners and their children are not eligible unless they are also legal tax dependents. 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. If there is a discrepancy between the total amount of expenses requested above and the total amount of the attached receipts, I will be reimbursed according to the total amount of eligible expenses on the attached receipts up to the annual or IRS maximum.

Employee Signature: _____ Date:

How To File A Health Care Flexible Spending Account Claim

- Complete the **Employee Information** section of the claim form.
- Complete the **List of Reimbursable Expenses** section of the claim form.
- Attach one or both of the following as supporting documentation to your claim:
  - **Fully itemized bills, receipts or statement** including dates of service, name of claimant, type of service, and cost of service from doctor, dentist, pharmacy, or other provider of service, showing any third-party payment made on account. **If a receipt is submitted for a service that would generally be covered by Health Insurance, then an Explanation of Benefits will be required**. Please note Balance Forward statements, credit card receipts, and canceled checks cannot be accepted as documentation.
  - **Explanation of Benefits** indicating deductible, co-insurance, and ineligible amounts not covered by any health plan under which you and/or your eligible dependents are covered.

    Note: Services will not be reimbursed based upon an Insurance estimate, or prior to services being rendered.
- Sign and date the **Authorization** section of the claim form *(note: typed name on signature line is not sufficient*).
- Retain copies of the claim form and supporting documentation for your records. Documents submitted will not be returned to you.
- Send the completed claim form and supporting documentation to: **Spending Account Service Center.** See contact information below.

Please file all claims prior to your plan's runout deadline. It is not necessary to accumulate your claims and submit only at year-end. Promptly submitting claims allows additional information to be requested of you as soon as possible.

For more information on eligible expenses under the Health Care Flexible Spending Account, please refer to IRS Publication 502 or the Health Care Flexible Spending Account Eligible Expense List, which can be found at the Spending Account Service Center.

SAVE TIME: Submit your claim online! https://SpendingAccounts.LH1ondemand.com
Note: Your employer may have a unique link! Check your benefit materials for user access credentials.
Questions? **Call the Benefit Service Center at 1800-580-6854**

Mobile App:	**Fax to:**	**Mail to:**	**Email to:**
	800-595-4642	Spending Accounts PO Box 350 Conshohocken PA 19428	claimsubmissions@marshmma.com