



HEALTH CARE FSA

How to File a Claim for Approval

Claim Filing Options:

- **File claim online:** Log in to your account at www.FSAFEDS.com 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:** 866-643-2245, **US Mail:** FSAFEDS Program – Claims, P.O. Box 14127, Lexington, KY 40512-4127

If you have questions: Visit the FSAFEDS website at www.FSAFEDS.com 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.

Who 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.

<p>Eligible Expense: For a list of eligible expenses specific to your plan, go to www.FSAFEDS.com and select "Eligible Expense."</p>	<p>Documentation Requirements: Proof of services from a third party, such as Explanation of Benefits (EOBs) from insurance company or provider of service.</p>
<ul style="list-style-type: none"> • A letter of medical necessity is required for any expense listed as "Yes (Letter)" on the eligible expense list to establish medical necessity. • Over the Counter medication: A prescription(Rx) is required for any over-the-counter medicines expense listed as "Yes (Rx)" on the eligible expense list. In addition to the required detailed receipt, an actual prescription written by a doctor (on a Rx pad or form) dated on or before the date the expense was incurred is required to verify that the over-the-counter medicine is prescribed for a medical condition. • Orthodontia Expense: for more information refer to the Orthodontic Quick Reference Guide. 	<p>Explanation of Benefits (EOBs) are recommended, especially if your insurance covered a portion of the expense. The service documentation will need to include:</p> <ul style="list-style-type: none"> • Provider Name • Service Dates (not payment date) • Patient Name • Type of Service • Out-of-Pocket Cost <p>or</p> <p>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.</p>

Instructions to fill out this form:

<p>Complete ALL account holder information.</p> <p>Use your documentation to complete each section of the form, including the following:</p> <ol style="list-style-type: none"> 1. Provider Name 2. Service Date(s) 3. Patient Name and Relationship to Account Holder 4. Type of Service 5. Patient Responsibility <p>Optional:</p> <p>Your provider signature can replace the need for separate documentation or other proof of service.</p>	<p>The screenshot shows the 'ACCOUNT HOLDER' section of the form. It includes fields for Last Name (SMITH), First Name (JOHN), ID Code (542100), and ZIP Code (010319). Below this is a table for services with columns for Provider Name, Service Dates, Patient Name and Relationship, Type of Service, and Out-of-Pocket Cost. Two entries are shown: Mercy Hospital (Lab) with a cost of 25.00 and Mercy Pharmacy (Rx) with a cost of 10.70. The form also includes checkboxes for relationship to account holder and type of service.</p>
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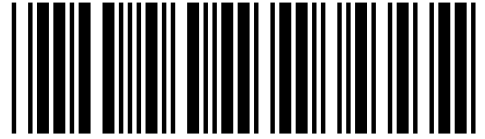
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HEALTH CARE FSA

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.com 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.com 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.)	<table border="1" style="margin: auto;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table>									Patient Name: _____ Relationship to Account Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Qualifying Child <input type="checkbox"/> Qualifying Relative <input type="checkbox"/> Other: _____ Type of Service: <input type="checkbox"/> Rx <input type="checkbox"/> Dental <input type="checkbox"/> Psych/Therapy <input type="checkbox"/> Ortho <input type="checkbox"/> Chiro <input type="checkbox"/> Co-payment <input type="checkbox"/> Lab <input type="checkbox"/> Vision <input type="checkbox"/> Hospital <input type="checkbox"/> X-Ray <input type="checkbox"/> OTC <input type="checkbox"/> Mileage	<table border="1" style="width: 100%; height: 40px;"> <tr><td></td></tr> </table>	
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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.com (available upon registration; enter username and password or click on New to the Site? link).