Flexible Spending Account Claim Form

Today's Date: _____/_____/_____ **# of pages:** _____ **Plan year beginning for:** 200__

❑ New Claim ❑ Resubmission of claim ❑ Response to claim denial

Employer Name/Division Name:	Employee Name:	
Address: ☐ **Please check if change of address**		
Social Security Number:	E-mail Address:	Home Phone: Work Phone:

Please note: Not all these accounts may apply to your group

❑ **Medical Expense Reimbursement Account** **Total Amount Requested** _____

- Enclose insurance company statement or itemized bill from provider showing date of service, services rendered, provider of service, amount paid and, if applicable, amount covered by insurance.
- Prescription claims **MUST** include the R_X number pharmacy receipt, not cash register receipt.
- Allowable reimbursement for mileage expenses

❑ **Dependent Care Reimbursement Account** **Total Amount Requested**_____

Must include provider Tax ID Number

❑ **Individual Premium Reimbursement Account** **Total Amount Requested**_____

Please attach proof that employee owns policy

❑ **Adoption Assistance Reimbursement Account** **Total Amount Requested**_____

❑ **105(h)/Health Reimbursement Account** **Total Amount Requested**_____

Date of Service	**E**mployee, **S**pouse or **D**ependent	Amount Requested	Type of Service (R_X copay, dental, etc.)	Service Provider/ R_X # (**MUST** be provided)
1.				
2.				
3.				
4.				
5.				

Please note the following requirements for claims submission:

* Please number each receipt according to its order of appearance on this form.
* IRS guidelines do **NOT** consider cancelled checks as valid documentation.
* Previous balances are **NOT** acceptable.
* All reimbursements will be made payable to the employee.

I certify that the above listed expenses have been incurred by me or by my spouse or dependent(s) and that they have not been reimbursed under any other health plan and that I will not seek reimbursement of the expenses under any other health plan.

EMPLOYEE'S SIGNATURE_____DATE_____

For faster service, fax claims to: (716) 855-7105 or (877) 855-7105

Or mail to: Flex Department, 17 Court Street, Suite 500, Buffalo, NY 14202-3204

Visit our website to access account information at www.padmin.com

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