uchealth

FLEXIBLE SPENDING ACCOUNT CLAIM FORM

☐ **Healthcare Spending Account**
☐ **Dependent Care Spending Account**

Employer Name	Employee Name	Employee's Last 4 SSN	Employee DOB

Healthcare Claims (for you and/or your dependents)

Date of Service	Provider	Type of Service (Rx, Medical, Dental, etc.)	Patient Name	Amount Requested
			Total Amount Requested	

Participants must submit a copy of the receipt(s), bill(s), or EOB(s) for the healthcare expense, detailing the provider name, address, dates of services, and type of service as stated below.

- **Covered by Insurance** – Expenses for services or items must be submitted to your insurance company before submitting for reimbursement under your Flexible Spending Account. When you receive the Explanation of Benefits (EOB) from your insurance company, include a copy with this completed claim form. If you have a copay, attach an itemized statement from your provider.
- **Not Covered by Insurance** – For services or items not covered by insurance, submit an itemized statement from the provider, showing the provider's name/address, patient name, date of service, and a description of service and amount paid along with this completed claim form.
- **Prescription drugs and medications** require a print-out of prescriptions from your pharmacy, or must be clearly identifiable on an itemized receipt. Quantities purchased must be reasonably able to be consumed during the current Plan Year. Items for maintaining general good health, cosmetic purposes and dietary supplements are not eligible expenses.

Balance forward statements, cancelled checks, credit card receipts or account statements are not acceptable.

Daycare Claims (dependent child or qualifying adult)

Complete this form and attach an itemized statement from your day care provider, or have your provider complete the information below. IRS regulations allow payment of services that have already been provided, not for services to be provided in the future. IRS regulations require you to report the provider's name, address, and Tax Identification Number on Form 244 with your personal income tax return. If your day care provider completes and signs this form, no other itemized statement is necessary.

Dates of Service	Daycare Provider Name	Daycare Provider Tax ID# Or SSN	Dependent Name	Dependent Age or Date of Birth	Amount Requested
				Total Amount Requested	

Daycare Provider Signature (applicable if no attached receipt)	**Date**

Employee Certification

- I certify that these eligible expenses have been incurred by me or my eligible dependent(s) and are not for cosmetic purposes, but for the treatment of an illness, injury, trauma, or medical condition.
- I understand the expense incurred means the service has been provided that gave rise to the expense, regardless of when I am billed or charged for, or pay for the service. The expenses have not been reimbursed and I will not seek reimbursement elsewhere.
- I understand that any amounts reimbursed may not be claimed on my income tax returns (or my spouse's income tax returns, if applicable).
- I have received and read the printed material regarding the reimbursement accounts and understand all of the provisions.
- I certify that the information provided is accurate and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and only for eligible participants. The expense(s) listed have not been reimbursed or are not reimbursable under any other plan coverage and will not be claimed as an income tax deduction.
- In the event of an erroneous or excess reimbursement, I understand I am required to reimburse the Plan for the improperly paid amount. I also understand failure to repay the Plan could result in adverse income tax consequences.
- I do understand that I will forfeit to the Plan any remaining dollars if do not incur eligible expenses by the end of the Plan Year and submit my claims for reimbursement by the end of the Plan Year.
- I certify that, to the best of my knowledge, the information shown on this form is correct.

Employee Signature	**Date**

Please submit completed and signed form to fsa@uchealth.org

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