



Health Care Flexible Spending Account Claim Reimbursement Form

How To Prepare Your Claim Form

Step 1 Complete all employee information. This form will be processed electronically. Print clearly and only in the spaces provided.

Step 2 Complete expense information. If the expense was incurred for an eligible dependent, indicate type of relationship in the box on the dependent name line. Use "C" for child, "S" for spouse or "O" for other.

Step 3 Sign and date the claim form and attach proof of expense. Bills, statements, or "Explanation of Benefits" (EOBS) from medical plan(s) are required proof of expense(s). Canceled checks are not sufficient evidence as proof of expense.

IMPORTANT! DO NOT combine multiple expenses on a single line. List each expense separately. Whether submitting single or multiple claims via fax, always send the claim form followed by its supporting documentation or receipts. Retain a copy for your records.

Employee Information

(PLEASE PRINT)

Please check this box if **any** of your information has changed

Name _____ Employer Name _____

Address _____ Email Address _____
(By providing your email address, you will receive electronic notifications)

City _____ State _____ Zip _____ Daytime Phone # _____

Social Security Number

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Instructions: Please use blue or black ink and print like this



0	1	2	3	4	5	6	7	8	9
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Expense Information

Start Date of Service			NOTE: Please report only one expense per block. Combining multiple expenses to one block may result in a delayed reimbursement.	Amount	
MONTH	DAY	YEAR		DOLLARS	CENTS
			NAME OF PROVIDER		
			TYPE OF SERVICE <input type="checkbox"/> DENTAL <input type="checkbox"/> HEALTH <input type="checkbox"/> VISION <input type="checkbox"/> PRESCRIPTION <small>DEPENDENT D.O.B.</small>		
			DEPENDENT NAME	RELATIONSHIP TO EMPLOYEE	
			NAME OF PROVIDER		
			TYPE OF SERVICE <input type="checkbox"/> DENTAL <input type="checkbox"/> HEALTH <input type="checkbox"/> VISION <input type="checkbox"/> PRESCRIPTION <small>DEPENDENT D.O.B.</small>		
			DEPENDENT NAME	RELATIONSHIP TO EMPLOYEE	
			NAME OF PROVIDER		
			TYPE OF SERVICE <input type="checkbox"/> DENTAL <input type="checkbox"/> HEALTH <input type="checkbox"/> VISION <input type="checkbox"/> PRESCRIPTION <small>DEPENDENT D.O.B.</small>		
			DEPENDENT NAME	RELATIONSHIP TO EMPLOYEE	
			NAME OF PROVIDER		
			TYPE OF SERVICE <input type="checkbox"/> DENTAL <input type="checkbox"/> HEALTH <input type="checkbox"/> VISION <input type="checkbox"/> PRESCRIPTION <small>DEPENDENT D.O.B.</small>		
			DEPENDENT NAME	RELATIONSHIP TO EMPLOYEE	

To Submit Your Claim:
 Fax to: (678) 762-5900
 Or Mail to: ADP Claims Processing, P.O. Box 1853, Alpharetta, GA 30023-1853
 Questions and Information: Call (800) 654-6695 or visit www.adpfsa.com

Total Expenses \$

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Certification

I certify that the expenses listed above qualify for reimbursement and have been incurred by me or by eligible members of my family. These expenses have not been reimbursed by my health care plan or any other health care plan, such as my spouse's. Additionally, these expenses are not being claimed as tax deductions under Section 213 of the IRS code. Bills, statements, or other proof of the expenses are attached.

SIGNATURE _____ DATE _____