UNITED ADMINISTRATIVE SERVICES

FSA REIMBURSEMENT FORM

For manual reimbursement, fax to: 408.288.4577 or email to: dzapien@uastpa.com.

Please complete all applicable spaces:

Grace Period Plans Only: Indicate the Plan Year from which claims should be paid: ***Claims without Plan Year designation will automatically be paid from Prior Plan Year balances. Once paid, claims will not be reprocessed.***	
☐ Prior Plan Year (Grace Period claims)	☐ Current Plan Year

Employer name:			
Employee name: First	Middle Initial	Last	Social Security Number

Home Address	City	State	Zip	☐ Check if address change

Health Care Receipts Attached:

DATE	AMOUNT
	$
	$
	$
	$
	$
	$
	$
Total:	$

Dependent Care (DCAP) Expenses: ***No proof of expense required when signature provided***

Provider's Signature	SSN or Tax I.D. #		Amount:
Provider's Name & Address	Date of Service		
	TO	FROM	$
Provider's Signature	SSN or Tax I.D.#		Amount:
Provider's Name & Address	Date of Service		
	TO	FROM	$
		Total:	$

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 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.

Employee's Signature _____ Date _____

Reimbursement Instructions:

1. After you have incurred an eligible expense during the plan year, complete a Reimbursement Form. Please note: Health care expenses must be processed first by your primary and secondary (if applicable) health plans.
2. Include the appropriate documentation with a signed reimbursement form: Health Care Expenses: Send the Explanation of Benefits (EOB) from your insurance company (if you have partial coverage for the expense) or an itemized bill (if you do not). The EOB or bill must contain the actual date of service, the name and address of the provider, a description of the services and the amount charged. Financial Agreements, Treatment Plans, bank / credit card statements and/or cancelled checks are not acceptable documentation. You may attach multiple HEALTH CARE receipts to this reimbursement form. Dependent Care Expenses: Submit your claim in one of the following ways; A.) Complete this reimbursement form containing your provider signature, address, Tax ID number, date of service, and the amount paid. This completed form serves as your receipt. B.) Or, complete this reimbursement form and submit with a receipt from your provider indicating date of service, amount paid and tax ID number.
3. Fax or email this entire sheet, completed and signed, along with the appropriate documentation to the address shown at the top of this page. Or you can mail it to the address shown at the bottom of this page. Please keep your original receipts with your tax records, submit legible copies with this form.
4. Health Care Expenses: We will reimburse up to the amount you elected for the year minus any previous reimbursements.
5. Dependent Care Expenses: We will reimburse up to the amount you have deposited in your account to date (through payroll deductions) minus any previous reimbursements.

Important Reminders:

✓ Only eligible expenses incurred during your Plan year are eligible for reimbursement. You will have a 90-day run out period after the end of the plan year, or date of termination, whichever is earlier, to submit acceptable / approved claims for expenses incurred during your plan year.
✓ An expense is incurred when the service is provided—not when you are billed or when you pay for the service.
✓ Due to the nature of orthodontia and prenatal billing, prepaid expenses for the plan year can be reimbursed before the service is complete.
✓ Any unpaid Dependent Care amounts (due to expenses exceeding the amount in your account at the time of the claim) will be paid out automatically as money accumulates in your account. You do not need to resubmit the claim.
✓ Notify your benefits representative within 30 days if you have a mid-year election change and wish to make a corresponding change to your DCAP and/or MRA election.