

# FSA CLAIM FORM



**If you have any questions call (866) 916-3475**  
**Claim Submission Methods**  
**Fax: (877) 213-8917**  
**Mail: P&A Group Attn: NC FSA Plan**  
**17 Court Street Suite 500 Buffalo, NY 14202**

Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_ # of pages Plan Year beginning for: 20\_\_\_\_

New claim                       Re-submission of claim                       Response to claim denial

Employee Name:	FSA ID Number or Social Security Number:
Address:	
E-mail Address:	Home Phone: (    ) Work Phone: (    )

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 Rx number pharmacy receipt, not the cash register receipt

Dependent Care Reimbursement Account                      Total Amount Requested:\_\_\_\_\_

*Note: you MUST include provider Tax ID Number in the service provider column below. If you do not remit a copy of your bill/contract, your provider must sign on the line below in lieu of submitting a receipt.*

Provider Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Service	Employee, Spouse or Dependent	Amount Requested	Type of Service (Rx, co-pay, dental expense, etc).	Service Provider/ Rx Number (Must be provided)
1.				
2.				
3.				
4.				
5.				

**CLAIM SUBMISSION REQUIREMENTS**

- Please number each receipt according to the 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, my spouse or my dependent(s) and that they have not been reimbursed under any other health plan. I will not seek reimbursement for these expenses under any other health plan.*

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_