

Flexible Spending Account Claim Reimbursement Instructions

1. Complete all information in **Section 1** (please print or type). **Please include your e-mail address if you want to receive an automatic e-mail notification whenever a claim is processed.**
2. Attach supporting documentation. Substantiation must accompany this request form in order for claims to be considered for reimbursement. Be sure to keep copies of receipts, bills, etc. for your records. Originals will not be returned. **All substantiation must include the following items to be eligible for reimbursement:**
 - Original **date** of service (not the date of payment)
 - Type** of service performed (refer to list of eligible expenses to identify valid services)
 - Provider's **name** and address (and Tax ID / SSN for Dependent Care expenses)
 - Amount** charged to you (do not include amounts reimbursed by another source)
3. For a **Health Care Spending Account Reimbursement Request**, complete all information in **Section 2** and attach proof of expense as described above. **IMPORTANT:** If participating in the limited-purpose HCSA, claims submitted can only be for either dental or vision expenses.
4. For a **Dependent Care Spending Account Reimbursement Request**, complete all information in **Section 2** and attach proof of expense as described above unless provider's signature is included on the claim form.
5. Sign and date **Section 3**.
6. **Fax, mail, scan/email** this form and supporting documentation directly to:

CBCA Flex

3510 Irwin Simpson Road, Suite B, Mason, OH 45040
Toll-free phone: (866) 754-1722 Toll-free fax: (866) 754-1833
Email: CBCAFLEX@Chard-Snyder.com. Website: www.cbcaflex.com

7. **Important Reminders:**

- Payments are issued after receipt and processing, subject to adjudication. **Transfer between accounts is prohibited.**
- Any items for which you are reimbursed **cannot be claimed again** as deductions or credits on your individual tax return at the end of the tax year.
- If a **Dependent Care** claim is submitted for an amount that is larger than the amount credited to your account, then payments will be issued according to the amount available. Anything requested above the available amount will "backlog" and will be released as additional credits are made to your account. **IRS Guidelines prohibit the advancement of Dependent Care Spending Account funds.**
- You may only be reimbursed for eligible expenses incurred **during** the current plan year. *Note: Orthodontia expenses are reimbursed as designated by the provider.*
- Payment will be made to you, the participant, only. **Payments cannot be made to an alternate payee.**

Flexible Spending Account Claim Reimbursement Request Form



1. Employee Information

Employer Name	Your Email Address
Your Name (Participant)	Home Address (Check if New Address <input type="checkbox"/>)
SSN	Daytime Phone
City	State
	Zip

If your claim includes expenses incurred by a spouse or eligible dependents, please provide the following information:

Name	Relationship to Employee	Date of Birth
_____	_____	_____
_____	_____	_____

2. Reimbursement Request

Please indicate your qualifying expenses for reimbursement below. **Do not include expenses reimbursed by any other source.** Attach bills, receipts, Explanation of Benefits Summaries (EOBs) or other claim documentation. Documentation must include dates of service, description, provider's name and the expense amount. Cancelled checks are NOT sufficient proof of your claim.

Health Care Spending Account - Please enter the following claim information:

Dates of Service	Description	Amount
_____	_____	_____
_____	_____	_____



IMPORTANT: If participating in the limited-purpose HCSA claims submitted can only be for dental or vision expenses.

Total Health Care Reimbursement Request

\$ _____

Dependent Care Spending Account - Please enter the following claim information:

Dates of Service	Provider's Name	Provider Tax ID or Social Sec #	Amount
_____	_____	_____	_____
_____	_____	_____	_____



Total Dependent Care Reimbursement Request

\$ _____

Dependent Care Provider's Signature: _____ Date: _____

3. Claim Certification

I certify that these expenses for which reimbursement is claimed from the Flexible Spending Account have been incurred by me, my spouse or my eligible dependent(s) and are not payable by any other benefit plan or program. I have not and will not itemize and deduct, nor claim credit for these expenses on my individual income tax returns.

Employee Signature: _____ Date: _____

(For office use only)

Claim # _____

Denial _____

Administrator Initials _____

Please submit this form with your claim documentation to CBCA Flex, 3510 Irwin Simpson Road, Suite B Mason, OH 45040

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