

NOTE: This claim form is ONLY for submitting receipts for purchases in which you paid out of pocket and did NOT use your FSA debit card.



FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT CLAIM FORM

Mail to: TPA eXchange: P.O. Box 1043, Matthews, NC 28106-1043 or Fax To: 866-223-6521

A. Company Name:

Employee Name (Please Print):

Social Security Number:

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Phone Number:

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Email Address:

B. This claim form MUST be completed. Incomplete forms will be returned by mail. Supporting documentation is required for all expenses (see next page). Please do not write "see attached" in this section. ***Canceled checks, credit card receipts and credit card statements are not acceptable proof of expense.***

Service Dates		Type of Service (Please circle)		Name and Relationship of Person Expense Incurred For	Expense Amount
From	To	H: Healthcare P: Parking	D: Dependent Care T: Transit And Name of Provider:		
		H D P T			\$
		H D P T			\$
		H D P T			\$
		H D P T			\$
		H D P T			\$
		H D P T			\$
Total Dependent Care \$		Total Healthcare \$		GRAND Total Both \$	

Dependent Care Provider Signature: _____

Dependent Care Provider Tax ID/SSN: _____

Metered Parking Affidavit: I hereby certify that I have incurred the expenses indicated above in the use of metered parking. If I am required to provide substantiation, then any additional burden of proof will remain my responsibility.

Employee Signature: _____

I request reimbursement for the expenses listed in this claim form under my employer's Flexible Spending Account Plan. I certify that I and or my eligible dependents (as determined under IRS rules) have incurred these expenses. I certify that any medical claim is for medical care excluding cosmetic purposes, is not incurred for general health purposes and does not constitute toiletries or cosmetics. I further certify that I have not received reimbursement for these expenses from any other source and will not seek reimbursement (or a tax deduction) from any other source.

Employee Signature

Date

Instructions:

1. All boxes in Section A (employee information) must be completed.
2. Complete all blanks of Section B, if expenses for which you are requesting reimbursement exceeds the available space, additional form(s) should be used. *To avoid delays in processing your claim, do not write, "see attached" in Section B.*
3. Sign and date the claim form. (Claim forms received without a signature will be returned.)
4. Attach supporting documentation for each claim.
5. Do not send cancelled checks, credit card receipts or statements. Only itemized receipts and bills are acceptable proof of expenses (see documentation requirements below).
6. Send the completed claim form and supporting documentation to:

**TPA eXchange
P.O. Box 1043
Matthews, NC 28106-1043
Or
Fax To: 866-223-6521
Phone: 877-224-8061**

Documentation Requirements

Healthcare Flexible Spending Account

- Name of employee or dependent receiving care
- Date(s) service was provided (must match claim form)
- Name of service provider
- Type of service provided
- Expense incurred
- Explanation of Benefits (EOB), if applicable, indicating the provider, date(s) of service, amount reimbursed and the amount outstanding
- If you are submitting receipts for prescriptions an RX number must be included with your documentation.

Dependent Care Flexible Spending Account

- Name of dependent receiving care
- Date(s) service was provided (must match claim form)
- Name, address and Tax I.D. Number of service provider. Signature of Provider
- Dates of Service
- Expense incurred