FSA Medical Expense Reimbursement Claim Form

Please check: ☐ Medical ☐ Dental

Employee Information

Employee Name	Social Security #
Address	
Worksite Employer	

Claim Information*

Date of Service	Provider Name	Patient Name	Relationship to Employee	Service Provided	Requested Amount
					$

I certify that the expenses for which I am seeking reimbursement from the FSA have been incurred by me or by an individual who qualifies as my spouse or my dependent for federal income tax purposes during the current plan year. I further certify that these expenses have not been reimbursed, nor shall reimbursement be sought from any other health plan coverage. I also certify that I have not, and will not claim a tax deduction or credit for these expenses on my federal income tax return, or on my state or local tax returns in violation of state or local law. I agree to submit and retain sufficient documentation for any expense for which I seek reimbursement.

Employee Signature: _____ Date: _____/_____/____

***Acceptable documentation:**

1. **An itemized billing from the medical provider**
2. **EOB (Explanation of Benefits)**
3. **Receipt for eligible items**

For Orthodontia Claims:

- When submitting your first orthodontia claim, you must submit the orthodontia contract along with a signed FSA Health Care Reimbursement form. This contract should indicate initial fee charged, estimated insurance payment, initial start date, duration of treatment and proof of partial or full down payment.
- For each monthly request for reimbursement, you must submit a completed claim form with an itemized bill from the orthodontist. The statement should show the monthly charge consistent with the original orthodontic contract.

Submitted claims will not be returned.

Please refer to www.irs.govfor more information on FSA medical expenses

Submit claims to: A1HR, 3829 Coconut Palm Drive, Tampa, FL 33619

A1HR Phone: 813-620-1661 Toll Free: 877-636-1661 Fax: 813-490-1191