Health Care Flexible Spending Account (FSA) Reimbursement Form

CERIDIAN

PARTICIPANT INFORMATION			
ID Number or SSN (required)	**LAST NAME**	**FIRST NAME**	**M.I.**
EMPLOYER NAME		**EMPLOYER ID/CLIENT CODE**	

HELPFUL TIPS

- Make copies of your supporting documentation. Submit the copies and retain the originals for your records. **Please *do not* highlight items or staple receipts.**
- Each expense *must* be accompanied by its receipt and/or Explanation of Benefits (EOB) from your insurance company showing Date of Service, Amount of Service, Provider and Type of Service (DAPT).

STEP #1 – Complete this section

- **Date of Service** (enter date service was incurred)
- **Type of Service** (use the codes in the box to the right)
- **Description** of service (i.e., eyeglasses, dental work)
- **Miles** (to be reimbursed for mileage expenses, write the number of miles driven to and from the provider; enter each trip *once*)
- **Tax** (enter the amount of sales tax charged for *each* item)
- **Amount** of service or item
- **Total Amount** (include Amount and Tax)

Type of Service codes:

MED:	Medical
VIS:	Vision
DEN:	Dental
OTC:	Over-the-counter
RX:	Pharmacy
ORTHO:	Orthodontia

Each expense is reviewed to determine eligibility under the plan. If the amount you request exceeds the amount of eligible expenses listed on your supporting documentation, you will be reimbursed for the total amount of eligible expenses on the documentation.

DATE OF SERVICE	TYPE OF SERVICE	DESCRIPTION	MILES (Optional)	TAX (Optional)	AMOUNT	TOTAL AMOUNT
				$	$	$
				$	$	$
				$	$	$
				$	$	$
				$	$	$
Please submit additional signed form(s) if more space is required.				**TOTAL AMOUNT REQUESTED**		$

STEP #2 – Sign the form

By submitting this form, I attest and agree to the following: 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 coverage period for myself and/or my legal dependent(s) under the plan. I certify that these expenses have not previously been reimbursed or will not be reimbursed under any other benefit plan, and will not be claimed as an income tax deduction.

EMPLOYEE SIGNATURE (Required)	DATE
X	

STEP #3 – Make copies of the supporting documentation

STEP #4 – Submit signed form(s) and copies of supporting documentation

Fax to: 866-717-3820 (Please do not use a cover sheet)

Claims with copies of documentation may also be mailed to: Ceridian FSA Services, P.O. Box 534451, St. Petersburg, FL 33747-4451
For Customer Service, please call: **877-799-8820**