Flexible Spending Account 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
·Reimbursement for eligible mileage expenses is permitted

☐ 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.				

Requirements for claims submission:
·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 _____/_____/_____