

Health FSA Reimbursement Form

Fax or Email this completed reimbursement form and appropriate documentation. Requests received via fax or email will be processed within five business days after receipt. Please keep original receipts for your records as required by the IRS. Fax (855) 495-3669 or email to membercare@mypeak1.com.

Employee Name: Last	First	Middle Initial	Last 5-Digits of Social Security Number		
Home Address <input type="checkbox"/> check if new address	Number/Street	Apt#	City	ST	Zip
Email Address <input type="checkbox"/> check if new email address					Daytime Phone Number () -
@			Company Name		

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 plan year for myself and/or my legal dependent(s). I certify that these expenses have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction. If there is a discrepancy between the total amount of expenses requested below and the total amount of the attached receipts, I will be reimbursed according to the total amount of eligible expenses on the attached receipts.

***Employee Signature Verification X** _____ **Date** _____
 *Required to process reimbursement

Step 1 Complete this section of the reimbursement form for eligible expenses incurred during your FSA plan year while you were a participant. Health care expenses must be processed by your insurance company first; they will provide you with an Explanation of Benefits (EOB). An expense is incurred when the service is provided, not when you are billed or pay for the service.

For Health Care expenses:	Date of Service	Claimant	Drug Name or Type of Service	Amount of Service
<ul style="list-style-type: none"> You must complete the boxes in this section for each expense in order for your claim to be processed properly. Use additional page(s) if needed. An Explanation of benefits (EOB) from your insurance company or an itemized bill (receipt) is required to process this claim. Your receipts must contain the following: <ul style="list-style-type: none"> Date of Service Type of Service Provider of Service Amount of Service Drug name must be stated on all receipts Copies of receipts for each expense claimed must be attached to the form. Expenses must be totaled on each page. 	/ /			\$.
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Total Health Care Expenses				\$.
<input type="checkbox"/> Check here if this claim was filed online or if this is for debit card substantiation				

Initial Login Instructions at mypeak1.com:

Participants effective PRIOR to 5/15/2011

Username: First initial of your first name, first initial of your last name, and the last 5 digits of your social security number. Example: JD12345
 Password: Password1
 Once you log in, you may change your username and the system will require the password to be reset.

Participants effective date AFTER 5/15/2011

Username: First initial of your first name, your last name, and the last 4 digits of your social security number. Example: jdoe1234
 Password: password1
 Once you log in, you may change your username and the system will require the password to be reset.