Aetna®

Flexible Spending Account Health Care Reimbursement

Mail or fax completed form and documentation to:
Aetna Inc.
P.O. Box 4000
Richmond, KY 40476-4000
Fax to: 1-888-238-3539 (1-888-AET-FLEX)
Phone: 1-888-238-6226
For the hearing impaired, call 1-877-703-5572 TDD/TTY

***** You must sign and date this form to avoid claim payment delay. *****

***** Refer to Instructions on reverse side. *****

1. Employee Information

Employee's FSA Identification Number	Employee's Last Name / First / MI	Daytime Telephone Number
W		( ) -

Street Address	City	State	Zip Code

2. Employer Information

Employer Name	FSA Control Number
Sarasota County Government	**811320**

3. Expense Information

Patient's First Name	Relationship to Employee	Date of Birth (MM/DD/YYYY)
	☐ Self ☐ Spouse ☐ Dependent	
Date(s) of Service (MM/DD/YYYY) From / /	Thru / /	**Total Amount Submitted $**

Patient's First Name	Relationship to Employee	Date of Birth (MM/DD/YYYY)
	☐ Self ☐ Spouse ☐ Dependent	
Date(s) of Service (MM/DD/YYYY) From / /	Thru / /	**Total Amount Submitted $**

Patient's First Name	Relationship to Employee	Date of Birth (MM/DD/YYYY)
	☐ Self ☐ Spouse ☐ Dependent	
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Patient's First Name	Relationship to Employee	Date of Birth (MM/DD/YYYY)
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Date(s) of Service (MM/DD/YYYY) From / /	Thru / /	**Total Amount Submitted $**

4. Orthodontia Expenses – Read Section 4 on the reverse side of this form before completing this section.

Patient's First Name	Relationship to Employee	Date of Birth (MM/DD/YYYY)
	☐ Self ☐ Spouse ☐ Dependent	
Date(s) of Service (MM/DD/YYYY) From / /	Thru / /	**Total Amount Submitted $**

5. Coordination of Benefits (COB)

Are you or any family members for whom you are requesting reimbursement eligible to receive benefits under any medical, dental, prescription or vision plan other than your primary coverage?

☐ Yes – You must include copies of all EOBs. ☐ No

6. Employee Certification

I certify that the expenses for which I am seeking reimbursement from the Flexible Spending Account have been incurred by me, or by an individual who qualifies as my spouse or my dependent for federal income tax purposes. I further certify that these expenses have not been reimbursed, nor shall reimbursement be sought, from any other health plan coverage, including a Health Savings Account (HSA). 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.

Any person who knowingly and with intent to defraud files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime.

Sign Here ► Employee Signature ______________________ **Date** __________

SUBMITTING YOUR CLAIM & PREPARING YOUR CLAIM FORM

- Retain copies for your files. Claim information cannot be returned.
- Do not highlight or otherwise mark the form or enclosed documentation. Highlighting and other marks make scanned and faxed documents difficult to read.
- Refer to www.fsanavigator.com for additional claim tips. Once in Navigator, click on the Claims & Balances link and then click on Claims. On the left side of the screen, click on Forms. Scroll down to Flexible Spending Account (FSA) and scroll to the Reimbursement section. Click on the link for Health Care and Dependent Care claim submission guidelines.

SECTION 1 – Employee Information

FSA Identification Number – As a participant with the FSA, you have been assigned a unique participant number. Your FSA ID Number is a 9 digit number preceded with a "W". If you do not know your W#, you can locate it from any one of the following sources:

- Explanation of Payment (EOP) – Paper EOPs always display your W#.
- Activity Statement – As an Aetna FSA participant you may receive an activity statement at least once a year; refer to this statement for your W#.
- Aetna Medical ID Card – If you have Aetna medical coverage, the W# displayed on your ID card is also used for your FSA.
- Member Services – Call FSA Member Services to inquire about your W#.

NOTE: If you prefer, you can use your Social Security Number in this field.

Employee's Address – Report an address change to your employer. To avoid misdirected claim payments, your employer must notify Aetna of your new address.

SECTION 2 – Employer Information

FSA Control Number – Your employer has been assigned a unique FSA plan number. If this form does not have that number pre-printed, you can locate this number from any one of the sources (with the exception of the Aetna Medical ID card) listed above in Section 1.

SECTION 3 – Expense Information

List and separate expenses by individual family members. **Attach the appropriate documentation for each claim.**
Note: A canceled check is not adequate documentation.

If you have insurance that covers part of this expense or your insurance does not cover this expense at all:

Submit the Explanation of Benefits (EOB) with your completed claim form. *You do not need to submit any other documentation with the EOB*. For a prescription drug claim, refer to the instructions to the right.

NOTE: Any third party documentation that indicates insurance has not yet paid (e.g., pre-treatment estimate) will be returned to you. You will need to resubmit the claim once you have received a final EOB; the EOB must show that the insurance carrier has paid its portion of the claim.

For an Rx claim or if you do not have insurance:

Submit the itemized receipt or statement from the doctor/dentist/ pharmacist/health care professional. This itemized receipt or statement must include:

- Name & address of doctor/dentist/pharmacist/health care professional
- Patient's name
- Date(s) of service
- Type of service
- Dollar amount charged

NOTE**:** Receipt from doctor/dentist/pharmacist must clearly document patient's financial responsibility.

SECTION 4 – Orthodontia Expenses

For Orthodontia claims, please follow these guidelines.

- When submitting your first orthodontia claim, you must submit the orthodontia contract from the orthodontist along with a signed Flexible Spending Account Health Care Reimbursement form. This contract must indicate initial fee charged, estimated insurance payment, initial start date, duration of treatment and proof partial or full down payment.
- For each monthly request for reimbursement, you must submit a completed and signed claim form with an itemized bill/statement or receipt from the orthodontist. This statement must show the monthly charge consistent with the original orthodontic contract.
- Future dates of services cannot be submitted. IRS guidelines require services to be incurred before you can be reimbursed. A reimbursement request for a service that will occur in a subsequent plan year will be returned to you for resubmission in that plan year.

SECTION 5 – Coordination of Benefits (COB)

When an expense is covered under more than one health plan, both Explanation of Benefits must be submitted in order to process the reimbursement.

SECTION 6 – Employee Certification

You must sign and date this form to avoid claim payment delays.