BlueCross BlueShield of South Carolina

An Independent Licensee of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans

Flexible Spending Account Claim Form ~ Medical Reimbursement

Employee's Name _____

Social Security Number _____-_____-_____

Employee's Daytime Phone (_____) _____

Please refer to the instructions on the back of this form to ensure you attach all required documents.

Name (last, first, middle)	Sex	Birthdate	Deductible	Coinsurance	Copayment	Other Expenses	Total Expenses
Employee			$	$	$	$	$
Spouse			$	$	$	$	$
Child			$	$	$	$	$
Child			$	$	$	$	$
Child			$	$	$	$	$
Child			$	$	$	$	$

Are you or any member listed above covered by another insurance plan?

Medical: ❑ **Yes** ❑ **No**

Dental: ❑ **Yes** ❑ **No**

Vision: ❑ **Yes** ❑ **No**

If "yes," please enclose a copy of your other carrier's Explanation of Benefits (EOB).

EMPLOYEE CERTIFICATION

I authorize my Flexible Spending Account (FSA) to be reduced by the amount of expenses listed above. The expenses incurred by myself or my eligible dependents are not reimbursable from any other source. I understand that these expenses cannot be claimed as credits or deductions on my income tax return. I further certify that I have read and understand the information outlined on the back of this form. The information on this form is true and correct to the best of my knowledge.

Employee's Signature _____ Date _____

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How to File this FSA Claim Form

1. To be reimbursed with funds from your FSA, you must file an **FSA Claim Form**. Attach an Explanation of Benefits (EOB) to this **FSA Claim Form**. An EOB is mailed to you after we have processed a medical, dental or prescription drug claim.

   In some cases, you may use an itemized bill or a cash receipt* from a service provider instead of an EOB. For example, if you purchase a hearing aid (not covered by the medical plans) you may attach the receipt from your hearing aid dealer to the **FSA Claim Form**.

   *An itemized bill or cash receipt must include the following:

   a. Name and address of the provider
   b. Detailed statement of services rendered, with dates of services

   For prescribed over-the-counter medicines that are reimbursable from your medical FSA, you must attach the prescription and the receipt which should include the date, name of the retailer, and a list of products purchased.

2. Please group all documents in order of the individual's name, and then by date of service.

   Mail the completed **FSA Claim Form** with attachments (EOBs and/or itemized bills) to the address below.

3. Keep copies of all claims submitted. Documentation mailed with this claim form will not be returned.

4. You must submit all FSA claims by the last day of the specified run-off period of the following year for expenses incurred during the plan year. Check with your company's Human Resources department for the exact date your run-off period ends. Any money remaining in your account after the end of the plan year will be forfeited under Internal Revenue Service (IRS) guidelines.

How to Contact Us

Mailing address: **PSA Unit**
BlueCross BlueShield of South Carolina
P.O. Box 100237
Columbia, SC 29202

Fax: **(803) 264-6423**
Phone: **toll-free 1-800-300-5248**