FSA 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

☐ 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.				

CLAIM SUBMISSION REQUIREMENTS

- 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:_____/_____/_____