BENEFITHELP
*Solutions*

# FLEXIBLE SPENDING ACCOUNT CLAIM FORM
## Public Employees' Benefit Board
## Group #8743

Member Benefit Number (P########): _____

Employee Name: _____
(Last) (First) (MI)

Home Address: _____
(Street)

_____
(City) (State) (Zip)

IMPORTANT - Instructions for completing a claim form:

1. Complete the entire claim form, including signature and date. Failure to complete the form in its entirety (including the itemization of each expense), and attaching supporting documentation may result in a delay in processing your claim. If more space is required, please attach a separate sheet that includes the same information on the form.
2. Attach supporting documentation. Canceled checks, credit card receipts/statements or balance forward or balance due statements are not acceptable.
   a. To submit healthcare or dental expenses, attach supporting documentation that includes the date of service, name of provider, the service performed and amount of the charge(s). An Explanation of Benefits from your insurance company or an itemized billing statement or receipt from your provider is an acceptable form of documentation.
   b. To submit prescription expenses, attach the Rx label or an itemized pharmacy ledger that include the date of service, pharmacy name, the Rx # and the amount of the prescription(s).
   c. To submit orthodontia expenses, attach a copy of the orthodontia contract. The orthodontia contract must include the total charges, less insurance payments or down payments, date treatment began and the length of treatment. We may request additional information.
   d. To submit dependent care expenses, attach documentation that includes the date(s) of service, name of the provider, the tax ID# or social security number, who the care was for and the amount of the charge(s) or have your provider sign below. Childcare expenses are for IRS tax dependents 12 and under. Adult care expenses are for IRS tax dependents residing in the participant's home. Educational and Kindergarten expenses or after school activities (i.e.: ballet, soccer, karate) are not eligible for reimbursement.
3. Keep a copy of the completed claim form and supporting documentation for your files.

**Healthcare Expenses** – *Please complete a separate line for each expense. Attach a separate sheet if needed. Attach supporting documentation as explained in #2.*

| Date of Service From: mm/dd/yy | To: mm/dd/yy | Name of Provider | Name of Dependent/Self | Amount Requested | | FOR INTERNAL USE ONLY |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | TOTAL: | | | |

**Dependent Care Expenses** - *Please complete a separate line for each expense. Attach a separate sheet if needed. Attach supporting documentation as explained above in 2.d, or have your dependent care provider sign below. Dependent care provider cannot be an IRS tax dependent or a dependent under the age of 19.*

| Name of Dependent | Age | Period Covered From | Period Covered To | Name, Address & Taxpayer Identification Number of Provider | Amount Requested | | FOR INTERNAL USE ONLY |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | TOTAL: | | | |

The above amount has been received for dependent care expenses for the time period stated above:

_____ _____ _____
Dependent Care Provider Signature | Tax ID#/SS# | Date

I request reimbursement from my Flexible Spending Account for the above listed expenses paid or to be paid by me. I certify these expenses are not covered or reimbursable from any other source. I understand that I cannot use expenses reimbursed through the healthcare account as tax deductions and I cannot use expenses reimbursed through the dependent care account as a tax credit when filing income tax returns.

Participant's Signature: _____ Date: _____

Submit this Claim Form and supporting documentation to:
BenefitHelp Solutions, Attn: FSA, PO Box 67230, Portland, OR 97268 or Fax: 503-765-3554 or 1-877-277-7279
www.benefithelpsolutions.com