Employee Health Flexible Spending Account (FSA) Claim Form

Company Name: ____

____
Employee First and Last Name

____
Home Address (Street/City/State/Zip)

____
Phone Number

HEALTH FSA ELIGIBLE MEDICAL EXPENSE REIMBURSEMENT INFORMATION:

***Read instructions on the following page before completing this claim form**

Date of Service	Name of Service Provider (doctor, facility, etc.)	Name of Person Receiving Service & Relationship to Employee (spouse, child)	General Medical Expense Description	Amount of Expense
Proof of payment and/or medical insurance explanation of benefits for services incurred is required documentation for reimbursement			Total Medical Expense Reimbursement Request	$

Claims for future services will not be accepted

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under his/her employer's Health FSA with respect to such expenses and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense.

____
Signature of Employee Date Signed

For Office Use Only

Claim Number: ______________________________

Health Flexible Spending Account (FSA)
Employee Claim Filing Instructions

How To File A Claim:

- Complete all information on the claim form for each amount claimed for reimbursement. If you have multiple lines of reimbursement use a second claim form.
- Make sure the claim does not include items for more than one calendar year. Use different claim forms for different years.
- You must sign and date the claim form.
- Attach a copy of your proof of payment and or medical insurance **E**xplanation **O**f **B**enefits **(EOB)** which supports each reimbursement request. Proof of payment documentation can include provider billing statements, invoices, or receipts showing payment applied and nature of service provided. Proof of payment and description of service are required to receive reimbursement.

Claim Form:

If you **mail** your claim with EOB's or receipts, remember to keep a copy of the claim form and supporting documents for your records.

Where To Send A Claim:

Mailing Address: Stearns HR Compliance and Consulting
Attn: Claims Department
P.O. Box 866
Sterling Heights, MI 48311

Phone: (877) 6COMPLY

Email: service@stearnshr.com