Health FSA Reimbursement Form

page _____ of _____

Fax to: (877) 488-6454 Please do not use a cover sheet when faxing. For faster service fax this entire sheet along with the appropriate documentation.

*** You may type your information directly on this form before printing. Press tab after each entry.**

Employee Name: Last | First | Middle Initial | Social Security Number - -

Home Address ☐check if new | Number/Street | Apt# | City | ST | Zip | Daytime Phone Number ( ) -

Email Address ☐check if new | Company Name | Client Code

Reimbursement Request Total Health Care Expenses $

To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for myself and/or my legal dependent(s). I certify that these expenses have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction. If there is a discrepancy between the total amount of expenses requested above and the total amount of the attached receipts, I will be reimbursed according to the total amount of eligible expenses on the attached receipts.

Employee Signature X _____ **Date** _____

Required to process reimbursement

Step 1. Complete this section of the reimbursement form for eligible expenses incurred during your FSA plan year while you were a participant. Health care expenses must be processed by your insurance company first, they will provide you with an Explanation of Benefits (EOB). An expense is incurred when the service is provided, not when you are billed or pay for the service.

For Health Care expenses:

- You must complete the boxes in this section for each expense in order for your claim to be processed properly.
- Use additional page(s) if needed.
- An Explanation of Benefits (EOB) from your insurance company or an itemized bill(receipt) is required to process this claim.
- Your receipts must contain the following:
  - Date of Service
  - Provider of service
  - Type of Service
  - Amount of service
- Rx number or drug name must be stated on all receipts.
- Copies of receipts for each expense claimed must be attached to the form.

Date of Service	Provider	RX number, Drug Name or Type of Service	Amount of Service
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$

Subtotal health care expenses $

Step 2. Fax to (877) 488-6454. Return this completed reimbursement form and appropriate documentation. Requests received via fax will be processed the later of two business days after receipt or prior to your next scheduled reimbursement date. If you prefer, mail to: Ceridian FSA Services, P.O. Box 534134, St. Petersburg, FL 33747. Claims received via mail may require one additional day for processing. Please keep original receipts as required by the IRS.

Visit www.ceridian-benefits.com 24 hours a day to obtain account information and additional reimbursement forms. For additional information, please call our customer service center at (877) 799-8820 Monday through Friday, during the hours of 8 a.m. to 8 p.m. Eastern Time.

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