

# FSA Reimbursement/Substantiation Form



Employer \_\_\_\_\_

Employee Name \_\_\_\_\_ SS# \_\_\_\_\_ Phone # \_\_\_\_\_

<p style="text-align: center;"><b>PLEASE READ CAREFULLY</b></p> <p><b>These rules apply to all reimbursement requests and flex card substantiations</b></p>	<ol style="list-style-type: none"> <li>1. For healthcare reimbursement requests, attach an Explanation of Benefits (EOB) from your health/dental plan for out of pocket expenses such as deductibles or coinsurance.</li> <li>2. For Dependent Day Care reimbursement requests, attach a third party itemized receipt to include the dependent's name, dates of service, day care provider's name, Tax ID number and address.</li> <li>3. Mbi Flex card users submitting an itemized receipt for your debit card purchase must check the box indicating <i>Debit Card Purchase Substantiation</i>. The itemized receipt must indicate the provider's name, patient name, date of service, charge for each service/supply, type of service/supply, reason for use, and out of pocket expenses that you are responsible for.</li> <li>4. Cash register receipts are acceptable only for eligible over the counter items if they include the date of service, the supplier's name and a clear description of the item.</li> <li>5. Cancelled checks or hand written explanations or descriptions of services are not acceptable.</li> <li>6. One claim form can be used for a combination of family members and/or expenses.</li> <li>7. Reimbursement will be made only to the individual employee.</li> <li>8. Separate claim forms must be completed for expenses incurred in different calendar years.</li> <li>9. Auto rollover participants should not request reimbursement for healthcare claims processed by FSAI. Any out of pocket expense will automatically apply to your healthcare flexible spending account.</li> <li>10. This form must be completed, signed, dated and mailed or faxed to FSAI with accompanying documentation.</li> </ol>
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### Un-reimbursed Healthcare Expense Claims

Patient Name	Date Expense Incurred	Name of Provider or Merchant	Expense Description	Charge	Debit Card Purchase Substantiation
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
<b>TOTAL HEALTHCARE EXPENSE CLAIM</b>					

### Dependent Care Expense Claims

Name of Dependent(s)	Date(s) of Service		Name, Address and Taxpayer Identification Number of Day Care Provider	Amount Incurred
	From	To		
<b>TOTAL DEPENDENT CARE EXPENSE CLAIM</b>				

I certify that these expenses for which reimbursement is claimed from my healthcare reimbursement account or my dependent care account have been incurred to me and/or my eligible dependents during the applicable plan year and are not payable by any other plan. I further declare that I have not and will not deduct these expenses on my federal income tax returns and my employer will provide this information on request of the IRS to the IRS.

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_

**Submit completed forms and documentation to:**

First Service Administrators, Inc. • 3035 Lakeland Hills Blvd • Lakeland, Florida 338805-2225  
 Fax Number: 888.285.5123 • Email Address: flexadmin@firstserviceadmin.com

**\*Access your account 24/7 at [www.online-enrollment.com/FI1st](http://www.online-enrollment.com/FI1st)\***