

HEALTH CARE SPENDING ACCOUNT REIMBURSEMENT REQUEST FORM

PLAN YEAR 200_____

SECTION A

ENROLLEE NAME				STREET ADDRESS					
SOCIAL SECURITY NUMBER	DAYTIME PHONE	AREA CODE	NUMBER	EXT.	CITY	STATE	ZIP CODE		

SECTION B

SUMMARY OF HEALTH CARE SPENDING ACCOUNT EXPENSES				DATES OF SERVICE ¹	
NAME OF PERSON RECEIVING SERVICES	RELATIONSHIP TO ENROLEE	NAME AND ADDRESS OF PROVIDER OF SERVICES ²	FROM MO/DAY/YR	TO MO/DAY/YR	AMOUNT TO BE REIMBURSED

TOTAL AMOUNT TO BE REIMBURSED \$ _____

¹ Use dates on which service was provided, **not** the date you paid for it.
² "Provider" means hospital, doctor, dentist, pharmacy, medical supply store, etc.

The above information is a true and accurate statement of unreimbursed medical expenses provided to me or my eligible dependents on the date(s) indicated. I have read and understand the information on the back of this form. I understand that I am responsible for misrepresentation regarding requests for reimbursement.

ENROLLEE SIGNATURE: _____ **DATE:** _____

FOR OFFICE USE ONLY		
DATE	AUTHORIZATION #	INITIAL

NEW YORK STATE FLEX SPENDING ACCOUNT
 A STATE EMPLOYEE BENEFIT THAT PUTS MONEY IN YOUR POCKET

HEALTH CARE SPENDING ACCOUNT

INSTRUCTIONS FOR REIMBURSEMENT

General Instructions:

- Make sure you complete Section B in its entirety.
- Reimbursement cannot be claimed if the cost can be reimbursed under any other source.
- Services must have been incurred to receive reimbursement. You may not request reimbursement until you have received the service, regardless of when you pay for it.
- The expenses for which you receive reimbursement cannot be claimed on your income tax return.
- According to IRS regulation, any unused year-end balance in your spending account may not be carried over to the next plan year. It will be forfeited to New York State as your employer.
- Be sure to sign and date this form, after reading it carefully. Mail or fax the completed form to FBMC and keep a copy for your records.
- You may access your account information or request Reimbursement Request forms 24 hours each day by calling FBMC's toll-free Interactive Benefits Information Line at 1-800-865-3262.

Documentation Instructions:

- To request health care expense reimbursement, a copy of your statement, bill or receipt from your health care service provider(s) showing the services received must be attached to this form. This statement must clearly identify the service provider's name and address, date and type of service provided, and amount of expense.
- For reimbursement of prescription costs, you must supply prescription name and number.
- Copies of cancelled checks are not sufficient documentation of incurred expenses.
- Please send legible photocopies of your original statements, bills or receipts, and retain the originals for your records.
- Expenses for "cosmetic surgery" are ineligible for reimbursement through the Health Care Spending Account. The services must promote proper function of the body or must be designed to treat, prevent, cure or mitigate a specific medical condition as defined by IRS regulations. A letter from your health care provider indicating the services are medically necessary must be submitted with the request for reimbursement of services that are generally considered cosmetic in nature.
- Orthodontic procedures for primarily cosmetic reasons are not eligible for reimbursement. All orthodontic claims must be submitted with a letter of medical necessity signed by your provider.

Period of Coverage:

- Reimbursement can only be made for expenses resulting from services that have been provided within your period of coverage. Your period of coverage is January 1 through December 31 if you enroll during the open enrollment period. If you enroll during the plan year as a new hire, your period of coverage begins on the 61st calendar day of your employment. If you terminate employment or take an unpaid leave of absence during the plan year, your period of coverage will end once you leave the payroll and stop contributing to your account.
- If a service is provided during your current period of coverage and will continue to be provided in a subsequent plan year, you will not receive reimbursement for the services you receive in that subsequent plan year unless you re-enroll in the Health Care Spending Account and submit a reimbursement request form for that period.
- If dates of service begin in one plan year and end in the next plan year, and you are enrolled for both years, please prorate the expenses and complete a separate form for each plan year.
- New York State has allowed for a 90 day grace period after the end of your plan year during which you may submit reimbursement requests for services which occurred during your period of coverage. Refer to your enrollment book for detailed information.

MAIL FORM TO:

**Fringe Benefits Management Company
Post Office Box 1800
Tallahassee, Florida 32302-1800
Customer Service: (800) 342-8017**

OR...

FAX FORM TO: (800) 743-3271

***If you fax your reimbursement request form to FBMC,
do not mail the form as well.***