HEALTH CARE SPENDING ACCOUNT
REIMBURSEMENT REQUEST FORM

PLAN YEAR _____

SECTION A

ENROLLEE NAME					STREET ADDRESS		
NYS EMPLID	DAYTIME PHONE	AREA CODE	NUMBER	EXT.	CITY	STATE	ZIP CODE

SECTION B

SUMMARY OF HEALTH CARE SPENDING ACCOUNT EXPENSES			DATES SERVICE PROVIDED		
NAME OF PERSON RECEIVING SERVICES	RELATIONSHIP TO ENROLLEE	NAME AND ADDRESS OF PROVIDER OF SERVICES (ex.: hospital, doctor, dentist, pharmacy, medical supply store)	FROM MO/DAY/YR	TO MO/DAY/YR	AMOUNT TO BE REIMBURSED

TOTAL AMOUNT $_____

I understand, agree and certify to the following:

- I will use my HCSAccount only to pay for IRS-qualified expenses, permitted under the HCSAccount plan, that are provided to me, my spouse and my IRS-eligible dependents, on the date(s) indicated above as being incurred within my period of coverage during the Plan Year.
- I will request reimbursement only after the health care services have been provided.
- I have not and will not seek reimbursement through any other source, and will exhaust all other sources of reimbursement before seeking reimbursement from my HCSAccount.
- I will collect and maintain sufficient documentation to validate my reimbursed HCSAccount expenses.
- I will not claim any reimbursed HCSAccount expense for any federal income tax deduction or credit.
- I specifically release New York State and FBWW from any liability resulting from either my participation in the HCSAccount or any misrepresentation I make regarding my requests for reimbursement.
- I have read and understand the information contained on the front and back of this form.

ENROLLEE'S SIGNATURE: _____ **DATE:** _____

REV.05/14

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

FOR OFFICE USE ONLY	DATE	AUTHORIZATION #	INITIAL

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 has been or 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 FBWW and keep a copy for your records.
- You may access your account information or obtain reimbursement request forms 24 hours each day by visiting www.myFBMC.com or calling FBWW's toll-free Interactive Benefits Information Line at 1-800-865-3262.
- The standard mileage rate reimbursable for use of an automobile to obtain medical care is subject to change by the IRS annually. Visit the Flex Spending Account website at *www.flexspend.ny.gov* for the current rate. Your request for mileage reimbursement must include documentation (such as a receipt from a doctor's office) to verify that the travel is related to medically necessary treatment.

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 patient's name, service provider's name and address, date and type of service provided, and amount of expense. For reimbursement of prescription drug costs, your receipt must also include the prescription name and number. OTC drugs require a written prescription in order to be reimbursed.
- At the beginning of the Plan Year in which you seek reimbursement for orthodontia expenses, you must submit a copy of the service contract between you and the orthodontist describing the payment arrangement/schedule.
- Copies of cancelled checks or charge card receipts are not sufficient documentation of incurred expenses.
- Submit legible photocopies of your original statements, bills or receipts, and retain the originals for your records. Do not highlight any portion of the receipts or statements, as it may make the documents illegible and result in your claim being rejected.
- Expenses for cosmetic services and procedures, and items that have a personal, living or family use are ineligible for reimbursement through the HCSAccount. The health care services must promote the 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, personal, living or family in nature.

Period of Coverage:

- Reimbursement can only be made for expenses resulting from medically necessary 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 consecutive calendar day of your employment. If you enroll during the Plan Year due to a change in status, your period of coverage will be based on the date your CIS request is received by the Plan. 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 HCSAccount and submit a reimbursement request form for that period of coverage. For services that require a letter of medical need, a new letter from your health care provider indicating the services are medically necessary must be submitted with the request for reimbursement in the subsequent Plan Year.
- 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 allows for a 90-day runout period after the end of your Plan Year during which you may submit reimbursement requests for services that were received during your period of coverage.

MAIL FORM TO:

Fringe Benefits Management Company, a Division of WageWorks
Post Office Box 1820
Tallahassee, Florida 32302-1820
Customer Service: (800) 358-7202 (option 1)

OR…

FAX FORM TO: (800) 743-3271

OR…

SUBMIT FORM ONLINE AT: www.myFBMC.com

If you either fax your reimbursement request form to FBWW or submit it online, do not mail the form as well.