

Health Care Flexible Spending (FSA) Reimbursement Form



PARTICIPANT INFORMATION

ID NUMBER OR SSN	LAST NAME	FIRST NAME	M.I.
EMPLOYER NAME MILWAUKEE COUNTY		EMPLOYER ID/CLIENT CODE L02582	

HELPFUL TIPS

- Make copies of your supporting documentation. Submit the copies and retain the originals for your records. Please do not highlight items or staple receipts.
- Each expense must be accompanied by its receipt and/or Explanation of Benefits (EOB) from your insurance company showing Date of Service, Amount of Service, Provider and Type of Service (DAPT).

STEP #1 – Complete this section

<ul style="list-style-type: none"> • Date of Service (enter date service was incurred) • Description of type of Service (i.e., Eyeglasses, Dental Crown, drug name) • Miles (to be reimbursed for mileage expenses, write the number of miles driven to and from the provider; enter each trip once) • Tax (enter the amount of sales tax charged for each item) • Amount of service or item • Total Amount (include amount and tax) 	<p>IMPORTANT CHANGE</p> <p>If your plan covers Over-the-Counter (OTC) items, you must submit a Ceridian Physician's Statement (available on the Forms Tab in your Consumer Portal) for OTC drug expenses you incur on and after 1/1/2011.</p>
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Each expense is reviewed to determine eligibility under the plan. If the amount you request below exceeds the amount of eligible expenses listed on your supporting documentation, you will be reimbursed the eligible amount. You will be reimbursed only for the eligible expenses itemized on the form.

DATE OF SERVICE	DESCRIPTION OF TYPE OF SERVICE	MILES (Optional)	TAX (Optional)	AMOUNT	TOTAL AMOUNT
			\$	\$	\$
			\$	\$	\$
			\$	\$	\$
			\$	\$	\$
			\$	\$	\$

Please submit additional signed form(s) if more space is required.	TOTAL AMOUNT REQUESTED	\$
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STEP #2 – Sign the form

By submitting this form, I attest and agree to the following: 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 coverage period for myself, my spouse, my dependent(s) and/or my adult child(ren) who are eligible under the plan. I certify that these expenses have not previously been reimbursed or will not be reimbursed under any other benefit plan, and will not be claimed as an income tax deduction.

EMPLOYEE SIGNATURE <i>(Required)</i> X	DATE
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STEP #3 – Make copies of the supporting documentation

STEP #4 – Submit signed form(s) and copies of supporting documentation

Fax to: 1-866-717-3820 (Please do not use a cover sheet)

Mail claims with documentation to: REIMBURSEMENT ADMINISTRATION, PO BOX 534451, ST PETERSBURG, FL 33747

For Customer Service, please call: **1-866-845-6271**