

**SEND CLAIM FORM TO:**

Total Claims Administration, Inc.  
 PO Box 21128  
 Fort Lauderdale, FL 33335-1128  
 Email: info@tcaclaims.com  
 Fax: (954) 767-5528  
 Customer Service: (954) 767-5500

**FLEXIBLE SPENDING ACCOUNT (FSA) CLAIM FORM**

**Please read these instructions before completing your FSA withdrawal request.**

1. Employee must complete **Part 1**. (if applicable, complete Part 2 "Health Care Expenses" and/or Part 3 "Dependent Day Care Expenses.")
2. Instructions for **Part 2**:
  - A. If expenses were covered by any benefit plan, **attach a copy** of the Explanation of Benefits (EOB) along with your FSA withdrawal form. Your insurance carrier (or a spouse's carrier or an individual plan) should pay before you request an FSA reimbursement.
  - B. If expenses are not covered by any benefit plan, **attach a copy** of an itemized receipt that includes the dates of service, service rendered, and total charge.
3. Instructions for **Part 3**: Request the day care provider to complete the Day Care Provider's Certification OR attach a copy of a receipt that includes the dates of service, day care provider's name, day care provider's tax ID or Social Security number and amount paid to provider.
4. Read the Certification For Reimbursement, **sign and date the form**. Make a **copy** for your records.
5. Mail the form to the address provided on this form. All reimbursement requests for a plan year made during the following year must be postmarked prior to the filing deadline, which is specified in your plan documents.

**PART 1 EMPLOYEE INFORMATION (Please Print)**

EMPLOYEE NAME (Last and First)	DATE OF BIRTH / /	DAYTIME TELEPHONE NO.
EMPLOYEE ADDRESS	EMPLOYEE NUMBER	EMPLOYER NAME Broward Health

**PART 2 HEALTH CARE EXPENSES (Please Print) Please place each expense on a separate line.**

PATIENT'S NAME	DATE(S) OF SERVICE MM/DD/YYYY		TYPE OF SERVICES	REQUEST AMOUNT
	From:	To:	Please circle the appropriate item below for each expense(s) MD=medical RX=medication VS=vision DN=dental HR=hearing	
			MD RX VS DN HR	
			MD RX VS DN HR	
			MD RX VS DN HR	
			MD RX VS DN HR	
<b>HEALTHCARE EXPENSES SUBTOTAL</b>				<b>\$</b>

**PART 3 DEPENDENT DAY CARE EXPENSES (Please Print) Please place each expense on a separate line.**

DEPENDENT'S NAME	DATE OF BIRTH	DATE(S) OF SERVICE MM/DD/YYYY	TYPES OF SERVICE(S)	REQUEST AMOUNT
		From: To:		
		From: To:		
<b>DEPENDENT DAY CARE EXPENSES SUBTOTAL</b>				<b>\$</b>
<b>TOTAL REQUEST FOR WITHDRAWAL</b>				<b>\$</b>

**Day Care Provider's Certification of Services Provided (Please Print)**

**Certification required when submitting claim for first time or if there is a change in provider**

I, the signer below, certify that the services listed in Part 3 above, were provided by me and charges have been paid in full.

DAY CARE PROVIDER'S COMPANY NAME AND SIGNEE'S NAME:	DAY CARE PROVIDER'S ADDRESS:
DAY CARE PROVIDER'S TAX ID#:	DAY CARE PROVIDER'S SIGNATURE:

**CERTIFICATION FOR REIMBURSEMENT**

I certify that any expenses for which I am requesting reimbursement from my Health Care FSA, as itemized above, were incurred by me (and/or my spouse and/or eligible dependents) for medical care as permitted under the Health Care FSA, and have not been and will not be reimbursed by any other plan. I certify that any expenses for which I am requesting reimbursement from my Dependent Day Care FSA, as itemized above, were incurred by me (and/or my spouse) for dependent care as permitted under the Dependent Day Care FSA, and have not been and will not be reimbursed by any other plan. I understand that expenses reimbursed through the FSA program cannot be used to claim any federal income tax deduction or credit. To the best of my knowledge and belief, my statements on this form are complete and true.

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

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Please complete the information on this form and review the following reminders:

- Is your Employee Number included on the form?
- Is your total requested amount included on the form?
- Did you attach copies of supporting documentation with your request?
- Did you sign and date the bottom of this form? If not, your request will be denied.
- Have you made copies of your request for your own personal records?

The following are examples of eligible supporting documentation that should be submitted with your request. A cancelled check is not adequate documentation. Please note, your FSA plan may **not** provide reimbursement of all expenses below. Refer to your plan documents for specific terms.

Small receipts should be taped to a standard 8.5"x11" sheet of blank paper and must be legible when scanned.

**Medical, Dental, Vision and Hearing Expenses**

For expenses partially covered by your medical, dental, or vision insurance plan, you must submit your *explanation of benefits* (EOB) statement with your completed claim form.

**You may submit a copayment receipt if this is your only expense.**

For expenses not covered by your medical, dental, or vision insurance plan, you must submit the following information:

- Name and address of the provider
- Dates of service
- Dollar amount charged
- Patient's name
- Type of service

**Prescription Drugs**

The prescription name or NDC#, date the prescription was filled, patient name, and cost should be included on the receipt. This information can be usually found on the prescription tags provided by the pharmacy.

**Dependent Day Care Services**

The Day Care Provider's Certification on the next page may be completed or a statement provided from the day care provider that includes the day care provider's name and tax ID or Social Security number, dates of service, and amount paid to the day care provider.