☐ **Use to offset claims that have been denied**

☐ **Pay out remaining amount of claim after offset**

☐ **Please reimburse**

☐ **Make this a monthly recurring payment**

Reimbursement Form for Flexible Spending Account (FSA)

Note: You will need this form when submitting for reimbursement. Please make copies. This form can also be downloaded at cds.healthplan.org.

Employee Information		
Last	First	Middle
Phone	Your Employer	
Member ID	Email	

Step 1: Complete the reimbursement form for eligible expenses incurred during your FSA plan year. When appropriate, health care expenses should be processed by your insurance company first. An expense is incurred when the service is provided, not when you are billed or pay for the service. Appropriate documentation must be included to process your reimbursement.

HEALTH CARE EXPENSES			
Date of Service	**Type of Service**	**Provider of Service**	**Reimbursement Amount**
Send Payment to ☐ **Me** ☐ **Provider**		**TOTAL REIMBURSEMENT REQUESTED**	$

DEPENDENT CARE EXPENSES			
Date of Service	**Provider of Service**	**Tax ID or SSN**	**Reimbursement Amount**
Send Payment to ☐ **Me** ☐ **Provider**		**TOTAL REIMBURSEMENT REQUESTED**	$

You may submit one reimbursement form for multiple service dates. For Dependent Care we will reimburse up to the amount you have deposited in your account to date, minus any previous reimbursements.

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 plan year for myself and/or my legal dependent(s). I certify that these expenses have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction.

Your Signature:_____ Date: _____
(Required to process)

Step 2: Please keep your original documentation. Submit this entire form and copies of your detailed bills, EOBs or other documentation to: The Health Plan – Account Processing PO Box 953 Charleston, WV 25323-0953 FAX: 304.347.3643 Email: customersolutions@healthplan.org Phone: 304.347.3640	Change of Address _____ _____ _____