Please read the following 3 notices then
scroll down to page 2 for the claim form and
scroll down to page 3 for claim form instructions.

Notice #1: Itemizing Expenses vs. Entering A Grand Total

On the claim form, you have the choice of itemizing your claim expenses or entering a "Grand Total" of your claim expenses.

Itemize your claim expenses, if you want a detailed listing of your submission. Enter a Grand Total of your claim expenses, if you simply want to indicate the total of all your claim expenses.

If you choose to enter a Grand Total, complete the first line of the "Claim Expense Information" section as follows:

- Dates of Service From: Enter the earliest service date of all claim expenses
- Dates of Service To: Enter the most current date of all claim expenses
- Dependent Care Provider: Enter "See Receipts"
- Description of Services: Choose "Grand Total"
- Claim Amount: Enter the total amount of desired reimbursement

Remember: You must use a separate claim form for each family member's expenses.

Notice #2: Submitting Your Claim

After completing your claim form online:

1. Choose "File | Print" on your browser menu,
2. Sign the printed form, and
3. Mail the form and copies of your claim expense receipts and/or insurer Explanation of Benefits (EOB) to BAS at the address shown on the form.

Notice #3: Saving Your Claim Form for Future Reference & Use

You can save either the blank version of this claim form or your completed version by choosing “File | Save As” from your computer’s web browser.

Once you save your claim form to your computer, you will be able to make copies for future use and change the claim information accordingly.

Warning: Save your completed claim forms to a secure folder on your computer since it will contain personal information.

Scroll down to page 2 for the claim form.
Scroll down to page 3 for claim form instructions.

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HEALTH CARE FSA CLAIM FORM

Mail or Fax To:
BAS
P.O. Box 62407
King of Prussia, PA 19406
FAX: 1.888.265.2144

Please type or print legibly.

*** Required Fields**

EMPLOYEE'S NAME * FULL NAME_____ * SOC. SEC. # * EMPLOYER	WORK PH # WORK EXT HOME PH #
EMPLOYEE'S STREET ADDRESS * CITY * STATE * ZIP	
Please complete this Dependent Section only if you are submitting claims for a dependent. Please note: A separate claim form must be used for each dependent's claims. **DEPENDENT'S NAME** FULL NAME_____ DATE OF BIRTH SOC. SEC. #	**DEPENDENT'S STATUS** ☐ HANDICAPPED ☐ FULL-TIME STUDENT

CLAIM EXPENSE INFORMATION

CLAIM YEAR ☐ * DATE OF SERVICE (MM/DD) FROM	TO	* HEALTH CARE PROVIDER'S NAME	DESCRIPTION OF SERVICES RECEIVED	CLAIM AMOUNT
			TOTAL =	

HEALTH CARE REIMBURSEMENT ACCOUNT CERTIFICATION

I certify that the expenses submitted herewith were incurred during the plan year and qualify for reimbursement as expenditures for medical care and not merely for general health or cosmetic purposes. The expenses have been incurred and paid by my spouse, my eligible dependent(s), or me and have not or will not be reimbursed from any other health plan, insurance, or any other source. The expenses have not or will not be claimed as deductions in filing income tax returns. I understand that if an expense is determined to be ineligible, I am responsible for reimbursing my plan for the expense.

X

SIGNATURE DATE

* Benefit Allocation Systems, Inc. / MyEnroll.com does not insure benefits under the health care flexible spending account plan. Your employer is solely responsible for determination of entitlement to, and payment of, any amounts due under the plan. Refer to the plan documents for more details.

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Form BAS claim_form_med_bw Ed. 01/2014

PO Box 62407, King of Prussia, PA 19406
T.800.945.5513 F.888.265.2144
www.BASusa.com

FLEXIBLE SPENDING ACCOUNTS

Employee instructions and information for completing this claim form.

1. Complete all employee information questions.
2. Complete all dependent information questions, if the claim expenses are for a dependent, (submit one claim form per dependent). Please note, if you are submitting health care FSA claims for a dependent, you must use the dependent claim form.
3. Indicate the dates of services rendered, name of provider along with a brief description of the services and the amount of reimbursement you are requesting.
4. When requesting reimbursement for medical expenses, you must provide adequate documentation. Generally, a copy of the Explanation of Benefits (EOB) provided by the primary insurer is acceptable, as is documentation from a provider that meets ALL IRS requirements for adequate substantiation.
5. Be sure to attach documentation, including itemized receipts, for all items to be reimbursed. Claims for all expenses without adequate documentation will be denied. If you are submitting claims for over-the-counter- medication, you must provide a prescription. If you are submitting claims for items that have both a medical and non-medical purpose, you must provide a Letter of Medical Necessity from a physician. If you are submitting dependent day care claims, you must provide the provider's tax ID number or a statement that you attempted to obtain the tax ID number but could not.
6. Once the form is completed, forward the form with the attached receipts to the above address.
7. A request for reimbursement which is not supported by proper documentation or does not qualify as a reimbursable expense under the employer's plan will be denied.
8. If you have any further questions regarding submitting your claims, please contact Benefit Allocation Systems, Inc. at 1-800-945-5513 or info@BASusa.com.

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