CLAIM FSA

EMPLOYEE INFORMATION

Employee Name:		Address:	
Company:			
Last Four Digits of Social Security #:		Has your address changed? Yes: ☐ No: ☐	

DEPENDENT CARE EXPENSES

	Service Start Date mm/dd/yyyy	Service End Date mm/dd/yyyy	Service Provider Tax ID# or SS#	Service Provider Name and Address	Dependent's Name	Age	Amount
1.							
2.							
3.							
					Total Dependent Care Expenses Requested		

I provided the dependent care as stated above.

Provider Signature: _____ Date: _____

HEALTH CARE EXPENSES

Please select a service with each claim.

	Patient	Service Start Date mm/dd/yyyy	Service End Date mm/dd/yyyy	Medical	Rx	Dental	Vision	OTCS Non-Drug	OTCD* Drug	Mileage $0.18 per mile**	Amount
1.											
2.											
3.											
4.											
5.											
										Total Health Care Expenses Requested	

*Every OTC drug claim requires a copy of the prescription to be attached. Please arrange documentation in order listed above.

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed were incurred during the current period under the company's Cafeteria Plan. The undersigned participant in the Plan understands that expenses are "incurred" when a service is performed or care is provided, not when the bill is paid. The undersigned certifies that all expenses for which reimbursement or payment is claimed on this form were incurred on the dates of service stated above. The undersigned fully understands that he or she is alone fully responsible for the sufficiency, accuracy, and veracity of all the information relating to this claim and unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including Federal, State, or City income tax on amounts paid from the Plan which relate to such expense.

Employee Signature: _____ Date: _____

TO SUBMIT A CLAIM:

Please review claim guidelines on the back of this sheet before submitting.

Submit your claim electronically through the Employee Portal

Submit your medical or dependent care claim on our mobile app, (available on App Store or Google Play), or

Send your claim form along with all supporting documentation directly to Paylocity via a secure email: batinfo@paylocity.com, fax: 314.909.6983 or mail: 10805 Sunset Office Drive, Ste. 401, St. Louis, MO 63127

Please do not submit a claim for reimbursement if you used your Debit Smart Card.

Paylocity issues checks on Thursday for all claims processed by Tuesday at 3:00 p.m. CST.
**Mileage to and from provider to your home. If rate has changed, amount will be adjusted at processing.

paylocity

GUIDELINES FOR CLAIMS SUBMISSION

THE INTERNAL REVENUE CODE PROVIDES THE FOLLOWING GUIDANCE

MEDICAL REIMBURSEMENT

The best receipt is an Explanation of Benefits from your insurance company.

If other receipts are submitted, they must show the following information:

1. Who rendered the service (name and address).
2. What type of service was rendered.
3. Date service was provided, not a billing or due date.
4. Amount of charge.
5. Any insurance payment, if applicable.

Canceled checks and credit card slips are not allowable receipts. Any amount claimed which is a "Previous Balance" or "Balance Forward," etc. cannot be paid unless the information stated in items 1-5 above is shown on the receipt.

Receipts must show all expenses incurred. Any over-payment, pre-payment, etc., for which no services are listed, cannot be reimbursed.

NOTE: In order to process your claim, all 5 pieces of information must be on each receipt. This includes receipts for orthodontic services.

OVER-THE-COUNTER (OTC) DRUGS WITH DOCTOR'S PRESCRIPTION AND ALL OTHER OTC ITEMS

Receipts must show the following information:

1. When and Who Sold the product (date, name, and address).
2. Type of OTC purchased. Must show product or brand name.
3. Amount of charge.

NOTE: Every OTC drug claim requires a copy of the prescription to be attached for each submitted claim. Prescriptions are not kept on file.

MILEAGE REIMBURSEMENT

Mileage incurred to and from your home or office to receive medical care is reimbursable through the FSA at the rate of $ 0.18 per mile. If rate has changed, amount will be adjusted at processing. Mile claim must include substantiation. (i.e. provider invoice, receipt, ect.)

DEPENDENT CARE REIMBURSEMENT

All receipts must show the following information:

1. Who rendered the service (name and address).
2. What type of service was rendered.
3. Date of original service, not a billing date.
4. Amount of charge.
5. Federal ID number (facility) or social security number (individual)

If your daycare facility does not provide a copy of a valid receipt, then you may have the provider sign off on this claim form attesting to the validity of these charges. Canceled checks and credit card slips are not allowable receipts.

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