



HEALTH CARE SPENDING ACCOUNT
Claim for Reimbursement



NAME OF EMPLOYER
Plainview-Old Bethpage Central School District
EMPLOYEE NAME SOCIAL SECURITY NUMBER
EMPLOYEE ADDRESS STREET CITY
STATE ZIP PHONE NO:

HEALTH CARE EXPENSES

Table with 6 columns: PATIENT NAME, DATES OF SERVICE (FROM, TO), PROVIDER OF SERVICE, (A) TOTAL CHARGE, (B) AMOUNT PAID BY OTHER SOURCES, (A-B) AMOUNT TO BE REIMBURSED. Includes a TOTALS row at the bottom right.

CERTIFICATION

I certify that the expenses for which I am requesting reimbursement meet all of the conditions listed below:

- They were incurred for services or supplies received by me or my eligible dependents under the plan.
- They were for services or supplies furnished while I was a participant in the Plan.
- I have not been reimbursed for these expenses, and they are not reimbursable from any other health plan.

I understand that reimbursement of these expenses can be requested and made only after I have collected all benefit payments available from all plans under which my eligible dependents and I are covered. I further certify that I have not deducted nor will deduct on my individual income tax return any of the expenses reimbursed through my Health Care Spending Account.

I understand that reimbursement will be made in accordance with the provisions of the plan which I participate. I accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting, and liability.

COMPLETION OF CLAIM FORM

- Complete all information on the claim form for each amount claimed for reimbursement.
• Make sure the claim does not include items for more than one plan year.
• You must sign and date claim form.
• A copy of a bill or other written statement from the provider of service is acceptable only when NO other insurance is applicable.
• Cancelled Checks/Credit Card Statements are NOT acceptable.
• If insurance is applicable, a statement/explanation of benefits from ALL MEDICAL/DENTAL INSURANCE CARRIERS SHOWING DEDUCTIBLE, COPAYMENTS AND PAYMENTS IS REQUIRED.

EMPLOYEE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

MAIL COMPLETED FORM TO: FBA OF SYOSSET, LLC
100 QUENTIN ROOSEVELT BLVD, SUITE 403
GARDEN CITY, NY 11530
PHONE (855) 374-6431 FAX (833) 930-1024
WWW.FBANATIONAL.COM