

## How To File a Health Care Claim

To complete a Health Care reimbursement request (a claim), you must submit a *Health Care FSA Claim Form* along with the receipts that clearly show an eligible expense was incurred. To complete a reimbursement request, you should:

1. Complete a *Health Care FSA Claim Form*
2. Attach itemized documentation
3. Submit the form and documentation to ADP



The *Claim Form* must be completed entirely, dated and signed. The supporting receipts or billing statements must state the vendor name, vendor contact information, purchase date, a description of the expense(s) and the expense amount. An Explanation of Benefits (EOB) from your medical provider can also be used as supporting documentation for your claim. A credit card receipt or canceled check is not adequate documentation. Credit card receipts often do not list the individual items purchased along with a description of the item. This is why you must save your purchase receipts, bills, itemized statements or EOB. Health Care claims cannot be processed for payment without proper supporting documentation.

You may submit up to four (4) purchases on a single Health Care Claim Form, using a separate line for each purchase. Please fax (fastest process) OR mail the documents, but please **DO NOT DO BOTH**. Be sure to keep a copy of your claim.

**Place the documents in this order: Health Care Claim Form first, then the supporting documentation. Please do not return the instruction pages with your form and receipts.**

**Fax to: 866-392-4090 (toll-free) or 678-762-5900**

OR

Mail to: ADP Claims Processing, P.O. Box 1853, Alpharetta, GA 30023-1853.

Good Receipt

Receipt Missing Information

**Rx Pharmacy** 01-25-2005  
 (999) 999-9999 CUSTOMER RECEIPT  
 33945 0034233 3322  
 Customer: **SARA SAMPLE**  
**VIGAMOX 0.5% EYE DROPS**  
 Instill one drop 4 times per day Pay: \$ 22.54  
 Rx Pharmacy, Inc. 123 Somewhere St., Anywhere, CT 99999

**ABC EYE ASSOCIATES**  
 123 MAPLE ST.  
 SOMEWHERE, CT 99999  
 DATE: 01-25-2005 TIME: 08:15AM  
 ITEM: 0034 VIS SALE  
 ACCT: XXXXXXXXXXXX30  
 AUTH: 9999  
**TOTAL: \$ 54.34**  
 I AGREE TO PAY ABOVE AMOUNT  
 ACCORDING TO CARD ISSUER AGREEMENT  
 (MERCHANT AGREEMENT IF CREDIT VOUCHER)  
 X \_\_\_\_\_

no description of items purchased

## Why Providing Documentation Is Important

The IRS has provided strict requirements stating that expenses reimbursed through a Flexible Spending Account must be substantiated using itemized receipts, bills, statements or Explanation of Benefits. All supporting documentation must reflect the vendor name, vendor contact information, date purchase/expense was incurred, a description of the expense and the expense amount. Health Care claims submitted without eligible documentation cannot be approved for payment, per IRS regulations. If your claim is declined for improper documentation, or if the expense is deemed as ineligible, you will be notified by ADP via U.S. Mail Service.

### Important Information About Health Care Service Dates and Expense Reimbursement

IRS regulations place strict guidelines on reimbursements for Health Care expenses. One point of confusion in these regulations is the difference between when an expense is paid versus when an expense is “incurred”. Per IRS regulations, expenses reimbursed through a Health Care FSA are based on the date the expense was incurred, not the date you paid for the service (with some exceptions). The date the expense was incurred is the actual date the services were provided or, in the case of purchasing products, the date you purchased the products.

Orthodontia expenses are an exception because the service typically spans multiple plan years. Your payment contract for the services will determine how you should submit the expenses on your FSA claims.

- Monthly/Weekly payments – Submit each payment as a separate expense along with the receipt showing the date of the payment period and type of service.
- In Full – If you paid for the entire treatment in a single payment at the start of service, submit the contract along with the plan of treatment and the amount paid with your claim form. **Note:** Even if the treatment is spread over 2 years, the entire amount will come out of your current plan year account.

When you have a large number of receipts to submit, you have the option of sending the details of your claims on a spreadsheet showing the date, provider, amount and type of service for each item. For the type of service, you should categorize your expenses as RX (for prescription), over-the-counter, co-pay, etc. The spreadsheet should then be submitted with your completed claim form(s) and receipts.

### Filing Multiple Expenses with the Same Service Date and Same Amounts

There may be times when you need to submit multiple expenses for the same amounts that were incurred on the same date. For example, you have two children who are both ill. Both children see the doctor on the same day and both children receive their own prescription with the same co-pay amount. The ADP claims processing system automatically categorizes claims based on the service date and amount and then compares those dates and amounts to claims you have already submitted. By filing a separate claim form for each child, the claim that is received and processed second will be marked as a duplicate claim. When submitting multiple claims with identical service dates and amounts, you should submit these expenses on the same claim form whenever possible. If the claims are for eligible dependents, be sure to include the dependent name and date of birth where indicated. This will help prevent eligible expenses from being inadvertently marked as duplicate claims.

You will receive a notification when a claim is marked as a duplicate. In the event a claim is mistakenly considered a duplicate, please contact your Participant Solution Center to have the claim status corrected. You can review your claims online at [www.flexdirect.adp.com](http://www.flexdirect.adp.com).

### Resubmitting an FSA Claim When Additional Information is Requested

On occasion, you may be asked to resubmit a claim because information you provided was insufficient. You may have neglected to provide required information such as an itemized receipt or perhaps you just forgot to sign the claim form. In the event you are asked to resubmit a claim, you must submit a new claim form with the requested information.

Depending on the situation, it may not be necessary to resubmit the entire claim. For example, if you filed a claim with four purchases and **only one purchase required additional information**, you would file a new claim for that one purchase with its supporting documentation. You should not resubmit the entire claim with all four purchases as this will result in duplicating the other three purchases and you would receive a letter indicating that these purchases had been duplicated. However, if you **forgot to include receipts** or if you **neglected to sign your claim form**, it would be necessary to resubmit the entire claim with all its supporting documentation.

For questions or additional information on resubmitting claims, please contact your Participant Solution Center or visit [www.flexdirect.adp.com](http://www.flexdirect.adp.com).

**Please do not return the instructions pages with your claim form and receipts.**

The Claim Form is designed so that you may complete the form on your computer by tabbing through the designated fields and typing in the required information. If you do not have access to a computer, please use black or blue ink to complete the form. Print clearly and only in the spaces provided. This form will be processed electronically.

**Step 1: Complete all Employee Information completely.** When completing the Employee Information, you should provide:

- ① Your name as it appears on your paycheck. Please print your name in ALL CAPITAL letters.
- ② Your employer's name.
- ③ Your complete mailing address.
- ④ A daytime phone number where you can be reached.
- ⑤ **Your 10-digit FlexID.** Locate your FlexID by logging into your account at [www.flexdirect.adp.com](http://www.flexdirect.adp.com) or by calling the Participant Solution Center at 1-(800)-654-6695.

**Employee Information** (PLEASE PRINT)

Name ① **SARA SAMPLE** Employer Name **ABC Company** ②  
(Please print name in ALL CAPITAL letters)

Address ③ **1234 Main Street**

City **Anytown** ③ State **US** ③ Zip **12345** ③ Daytime Phone ④ **555-222-1234**

FlexID ⑤  
 0 0 1 9 9 9 9 9 9 9

Instructions: Please use blue or black ink and print like this → 0 1 2 3 4 5 6 7 8 9

**Step 2: Complete the Expense Information.** Be sure to include only one expense per line provided. **DO NOT** combine multiple expenses on one line. The Claim Form allows you to submit up to four (4) expenses per form. Incomplete claim forms may result in claim denial or a request for more information. When completing the Expense Information, you should provide:

- ① The date the expense was incurred. This date should match the date on your receipt or EOB.
- ② The name of the physician or merchant from whom the expense was incurred.
- ③ The type of expense incurred (use the appropriate checkbox).
- ④ Qualified dependent information, if the expense is for a dependent. Provide the dependent name, the dependent's relationship to you (use "C" for Child, "S" for Spouse or "O" for Other) and the dependent's date of birth.
- ⑤ The total amount for the expense.
- ⑥ The total amount for all line items on the Claim Form.

★ **Faxing your claim package is the best submission route and will result in the quickest reimbursement.**

**Expense Information**

① Start Date of Service			NOTE: Please report <u>only one</u> expense per block. Combining multiple expenses in one block may result in a delayed reimbursement.	⑤ Amount	
MONTH	DAY	YEAR		DOLLARS	CENTS
0 5	2 6	0 8	NAME OF PROVIDER ② <b>Northside Pediatrics</b>	1 3 7	0 0
			TYPE OF SERVICE ③ <input type="checkbox"/> DENTAL <input checked="" type="checkbox"/> HEALTH <input type="checkbox"/> VISION <input type="checkbox"/> PRESCRIPTION		
			DEPENDENT NAME ④ <b>Michael Sample</b> RELATIONSHIP TO EMPLOYEE <b>C</b> ④    DEPENDENT D.O.B. ④ <b>01/14/99</b> ④		
				Total ⑥ Expenses → \$	1 3 7 0 0

**Step 3: Sign and date your Claim Form.** Claim forms received without a signed Certification cannot be processed.

**Certification**

I certify that the expenses listed above qualify for reimbursement under the applicable IRS regulations and guidance and have been incurred by me or by my eligible dependents. These expenses have not been reimbursed and I will not seek reimbursement under any other source. I understand that where an expense is determined to be ineligible, I am responsible for reimbursing the plan for any such expense. Additionally, these expenses are not being claimed as tax deductions under the IRS code. Bills, statements, receipts or other proof of the expenses are attached.

SIGNATURE Sara Sample DATE 05/31/05



# Health Care FSA Claim Form

**This document and any attachments are intended solely for the use of the sender and ADP and may contain information that is privileged and confidential. If you are not the intended recipient or its authorized representative, you are hereby notified that dissemination of this information is strictly prohibited. If you received this information in error, notify the sender immediately and destroy this document and all supporting attachments.**

### Tips to Remember when submitting Health Care FSA expenses.

1. **Include your 10-digit FlexID.** Locate your FlexID at [www.flexdirect.adp.com](http://www.flexdirect.adp.com) or by calling the Participant Solution Center at 1-800-654-6695.
2. Sign, Date and Fax your Claim Form *without* a cover page, followed by a copy of all supporting documentation including itemized receipts, bill or statements, and/or Explanation of Benefits (EOB) showing date, provider, amount and type of service. **Note:** Many credit card receipts do not show type of service and are therefore insufficient. Claims without sufficient documentation or signatures are ineligible for reimbursement.
3. **Do not** include a cover page or the instructions pages with your claim submission.

## Employee Information

(PLEASE PRINT)

Name \_\_\_\_\_ Employer Name \_\_\_\_\_  
(Please print name in ALL CAPITAL letters)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Daytime Phone \_\_\_\_\_

### FlexID

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**Instructions:** Please use blue or black ink and print like this



0	1	2	3	4	5	6	7	8	9
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## Expense Information

Start Date of Service			NOTE: Please report <u>only one</u> expense per block. Combining multiple expenses in one block may result in a delayed reimbursement.	Amount		
MONTH	DAY	YEAR		DOLLARS	CENTS	
			NAME OF PROVIDER			
			TYPE OF SERVICE			
			OVER THE COUNTER	DENTAL HEALTH VISION PRESCRIPTION		
			DEPENDENT NAME	RELATIONSHIP TO EMPLOYEE		
			NAME OF PROVIDER			
			TYPE OF SERVICE			
			OVER THE COUNTER	DENTAL HEALTH VISION PRESCRIPTION		
			DEPENDENT NAME	RELATIONSHIP TO EMPLOYEE		
			NAME OF PROVIDER			
			TYPE OF SERVICE			
			OVER THE COUNTER	DENTAL HEALTH VISION PRESCRIPTION		
			DEPENDENT NAME	RELATIONSHIP TO EMPLOYEE		
			NAME OF PROVIDER			
			TYPE OF SERVICE			
			OVER THE COUNTER	DENTAL HEALTH VISION PRESCRIPTION		
			DEPENDENT NAME	RELATIONSHIP TO EMPLOYEE		

**To Expedite Processing Please Fax Your Claim To**  
**1- (866) 392-4090 (toll-free)**  
Or Mail to: ADP Claims Processing, P.O. Box 1853, Alpharetta, GA 30023-1853

**Total Expenses** **\$**

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SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_