Medical Expense Claim Form — Flexible Spending Account

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Plan Year: _____

Name: _____ ***Employer:*** _____

Street: _____ ***SSN (Last four)*** ***XXX-XX-*** _____

City, State, Zip: _____ ***Participant Phone:*** _____

Check if New Address ☐ ***Email:*** _____

List Unreimbursed Medical Expenses by Classification *(Participants and IRS Eligible Dependents)*	**Dates of Service** MM/DD/YYYY START	END	**Amount** ($)
Medications		-	
Doctor/ Hospital Co-Pays and Deductibles		-	
Dental/ Eyes/ Hearing		-	
Medical Procedures/ Services and Therapy / Labs and Tests		-	
Over the Counter Medicine (attach copy of prescription for each)		-	
Other		-	
		Total	

- All claims require copies of bills/statements/receipts showing date and service. (IRS regulation)
- Cancelled checks/bank statement/credit card receipts are not adequate substantiation.
- Direct deposit payments are processed weekly on Wednesday and checks are mailed bi-weekly.
- Please allow 3 business days after processing date to receive your reimbursement.
- Expenses must be incurred during the plan year or before the termination date of employment to be reimbursed.
- All claims must be received by Monday to be included in that week's processing.

Certification

I, the undersigned, have incurred the expenses listed above that qualify for reimbursement under my employer's cafeteria plan. I have not been and will not be reimbursed for these expenses from any source including, but not limited to, insurance, this plan, or other programs offered by my, or my spouses, employer. I understand these expenses may no longer be claimed as deductions for income tax purposes since I am requesting reimbursement with funds deducted from my compensation on a pre-tax basis. I acknowledge I am solely liable for any taxes or penalties on ineligible expenses submitted through the medical flexible spending account. I, and only I, am responsible for the accuracy and validity of the submitted expenses and will retain substantiation. I hereby request reimbursement for these expenses, and, if applicable, reaffirm the authorization provided to Cafeteria Plan Advisors, Inc. to directly deposit the reimbursement into my bank.

Participant's Signature: _____ **Date:** _____

Attach copies of receipts and mail, fax, or scan as a PDF and email to info@cpa125.com
Retain originals for your records

Health Care FSA Eligible Expenses

BABY/CHILD TO AGE 13

- ☐ Lactation Consultant*
- ☐ Lead-Based Paint Removal
- ☐ Special Formula*
- ☐ Tuition: Special School/Teacher for Disability or Learning Disability*
- ☐ Well Baby /Well Child Care

DENTAL

- ☐ Dental X-Rays
- ☐ Dentures and Bridges
- ☐ Exams and Teeth Cleaning
- ☐ Extractions and Fillings
- ☐ Oral Surgery
- ☐ Orthodontia
- ☐ Periodontal Services

EYES

- ☐ Eye Exams
- ☐ Eyeglasses and Contact Lenses
- ☐ Laser Eye Surgeries
- ☐ Prescription Sunglasses
- ☐ Radial Keratotomy

HEARING

- ☐ Hearing Aids and Batteries
- ☐ Hearing Exams

LAB EXAMS/TESTS

- ☐ Blood Tests and Metabolism Tests
- ☐ Body Scans
- ☐ Cardiograms
- ☐ Laboratory Fees
- ☐ X-Rays

MEDICAL EQUIPMENT/SUPPLIES

- ☐ Air Purification Equipment*
- ☐ Arches and Orthotic Inserts
- ☐ Contraceptive Devices
- ☐ Crutches, Walkers, Wheel Chairs
- ☐ Exercise Equipment*
- ☐ Hospital Beds*
- ☐ Mattresses*
- ☐ Medic Alert Bracelet or Necklace
- ☐ Nebulizers
- ☐ Orthopedic Shoes*
- ☐ Oxygen*
- ☐ Post-Mastectomy Clothing
- ☐ Prosthetics
- ☐ Syringes
- ☐ Wigs*

MEDICAL PROCEDURES/SERVICES

- ☐ Acupuncture
- ☐ Alcohol and Drug/Substance Abuse (inpatient treatment and outpatient care)
- ☐ Ambulance
- ☐ Fertility Enhancement and Treatment
- ☐ Hair Loss Treatment*
- ☐ Hospital Services
- ☐ Immunization
- ☐ In Vitro Fertilization
- ☐ Physical Examination (not employment-related)
- ☐ Reconstructive Surgery (due to a congenital defect, accident, or medical treatment)
- ☐ Service Animals
- ☐ Sterilization/Sterilization Reversal
- ☐ Transplants (including organ donor)
- ☐ Transportation to Medical Facility

MEDICATIONS

- ☐ Insulin
- ☐ Prescription Drugs

OBSTETRICS

- ☐ Doulas*
- ☐ Lamaze Class
- ☐ OB/GYN Exams
- ☐ OB/GYN Prepaid Maternity Fees (reimbursable after date of birth)
- ☐ Pre- and Postnatal Treatments

PRACTITIONERS

- ☐ Allergist
- ☐ Chiropractor
- ☐ Christian Science Practitioner
- ☐ Dermatologist
- ☐ Homeopath
- ☐ Naturopath*
- ☐ Optometrist
- ☐ Osteopath
- ☐ Physician
- ☐ Psychiatrist or Psychologist

THERAPY

- ☐ Alcohol and Drug Addiction
- ☐ Counseling (not marital or career)
- ☐ Exercise Programs*
- ☐ Hypnosis
- ☐ Massage*
- ☐ Occupational
- ☐ Physical
- ☐ Smoking Cessation Programs*
- ☐ Speech
- ☐ Weight Loss Programs*

Note: This list is not meant to be all-inclusive, as other expenses not specifically mentioned may also qualify. Also, expenses marked with an asterisk (*) are “potentially eligible expenses” that require a Note of Medical Necessity from your health care provider to qualify for reimbursement.