

SECTION 1 – EMPLOYEE PROFILE (Please Print)

COMPANY NAME:	_____	DAYTIME PHONE #:	_____
EMPLOYEE SSN:	_____	EVENING PHONE #:	_____
EMPLOYEE NAME:	_____	EMAIL ADDRESS:	_____
MAILING ADDRESS:	_____	LOCATION:	_____

SECTION 2 – HEALTH CARE EXPENSES (Please provide the requested information for each expense on a separate line.)

<i>Dates of Service - (MM/DD/YY)</i>		<i>Patient Name*</i>	<i>Relationship to Employee</i>	<i>Name of Provider/Pharmacy*</i>	<i>Description of Service/Medicine/Drug*</i>	<i>Reimbursement Requested*</i>
<i>Start Date</i>	<i>End Date</i>					
<i>*Required Information</i>				<i>Total Reimbursement Requested*</i>		

SECTION 3 – DEPENDENT CARE EXPENSES (Please provide the requested information for each expense on a separate line.)

Dates of Service - (MM/DD/YY)		Dependent Name*	Relationship to Employee	Name of Provider*	Type of Service*	Tax ID # or SSN	Reimbursement Requested*
Start Date	End Date						

*Required Information

Total Reimbursement Requested*

SECTION 4 – PROVIDER PAYMENT SECTION (Please provide the requested information for each expense on a separate line.)

Expense Type		Provider Name*	Address*	City*	State*	Zip*	Amount	Frequency**
<input type="checkbox"/> Med.	<input type="checkbox"/> Dep. Care							<input type="checkbox"/> O <input type="checkbox"/> M
<input type="checkbox"/> Med.	<input type="checkbox"/> Dep. Care							<input type="checkbox"/> O <input type="checkbox"/> M

* Required Information * O = One Time, M = Monthly

SECTION 5 – AUTHORIZATION

I certify that the medical and/or dependent care expenses submitted for reimbursement were rendered to me or an eligible member of my family during the period I was a participant in the Health Care and/or Dependent Care Flexible Spending Account. I further certify that the medical care expenses are not eligible to be paid by the health care coverage provided through my employer or from any other source, such as my spouse's employer's health plan. I understand that I have the responsibility for any tax reporting or other requirements with respect to reimbursed expenses. I also understand that to the extent medical and/or dependent care expenses are reimbursed under the Health and/or Dependent Care Flexible Spending Account, they may not be claimed as expenses on my or my spouse's tax return. I also understand that the charges for which I am submitting reimbursement are eligible charges in accordance with IRS guidelines and IRS Publication 502. I certify that all over the counter medicine or drug expenses were incurred for medical care. I agree that I am responsible for any and all bank, savings or checking account charges that I incur. I agree to indemnify and hold harmless Parents H.R. Services from any responsibility relative to my credit status. I have received and read all printed material describing this program and all administrative materials defining the operation of this plan. I certify that I am responsible for compliance with all applicable administrative processes, tax regulations and documentation. I will retain a copy of this form and all original receipts for my records.

Signature

Date _____

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INSTRUCTIONS AND HELPFUL HINTS

GENERAL INFORMATION

Submit your completed claim form and attached documentation to Parente HR Services • 1200 Abington Executive Park • Clarks Summit, PA 18411 or fax your completed paperwork to 1-866-406-0946. Completed claim forms and documentation must be received by Noon (EST) on each processing deadline (call 1-800-307-0230 if you are unsure of your company's processing deadline). If your submitted claims are authorized, you will then receive reimbursement. Some claim reimbursements may be delayed due to coordination of benefits requirements.

SECTION 1 – EMPLOYEE PROFILE

- ☒ Please fill in all of the requested information.
- ☒ Remember to print or type in your information so we can process your claim quickly and accurately.

SECTION 2 – HEALTH CARE EXPENSES

- ☒ Please fill in all of the fields marked with an asterisk (*) as that indicates information that is required and must be filled in for your claim to be processed.
- ☒ Provide a copy of Explanation of Benefits (EOB) from your insurance company for qualified expenses (if available).
- ☒ If you are attaching a copy of an itemized statement as proof for a qualified expense, the itemized statement must contain the following information: (1) the name and address of the provider; (2) patient name; (3) date of service (date service was provided, not the date service was paid for); (4) description of service provided and (5) itemized charges.
- ☒ If you are submitting a claim for a prescription drug, **the prescription number (RX #) must be on the receipt** that you submit with your claim form.
- ☒ Cancelled checks and credit card receipts **ARE NOT** considered acceptable documentation of expenses listed on this form.
- ☒ Orthodontia claims require the following documentation: (1) an itemized statement and (2) the orthodontist's contract agreement showing the monthly payment.
- ☒ For qualified over-the-counter expenses, you must submit evidence of the purchase date and the specific medicine and/or drug name. **Vitamins, supplements and hygienic products are not qualified expenses and cannot be reimbursed through your FSA.**
- ☒ For all other expenses you must attach itemized receipts.
- ☒ Only submit copies of receipts, itemized statements, etc. You should keep all originals including receipts for your personal records.

SECTION 3 – DEPENDENT CARE EXPENSES

- ☒ Please fill in all of the fields marked with an asterisk (*) as that indicates information that is required and must be filled in for your claim to be processed.
- ☒ The service(s) you are submitting a claim for **must have occurred. We cannot reimburse payments for future dates of service.**
- ☒ Provide a copy of a receipt or bill from the provider of the service with this form.
- ☒ The bill/receipt submitted along with this form must include the following information: (1) the name of the provider; (2) the address of the provider; and (3) the provider's tax identification number or Social Security Number if your provider does not have a tax identification number.
- ☒ If there is not enough money in your Dependent Care Flexible Spending Account to pay the entire amount of the claim you submit, the claim will be paid up to the amount currently available in your account. You will not need to resubmit this claim again to receive full reimbursement. As more money accumulates in your account, you will automatically be reimbursed up to the full amount of the claim.

SECTION 4 – PROVIDER PAYMENT SECTION

- ☒ **Only complete this section if you are requesting that payment be made directly to your provider.**
- ☒ Please fill in all of the fields marked with an asterisk (*) as that indicates information that is required and must be filled in for payment to be made directly to a specific provider.

SECTION 5 – AUTHORIZATION SECTION

- ☒ Read the Authorization Section carefully.
- ☒ **Make sure to sign and date this form before submitting it for reimbursement.**