

Flexible Spending Account (FSA) Claim Form



Instructions For Quick Claim Processing:

- Fully complete & sign this claim form
- Attach copies of supporting EOB, receipts, vouchers, bills, etc.
- All receipts must detail each of the items summarized below
- Please list one expense per line
- Please print in dark blue or black ink when using this form
- Minimum Total Reimbursement = \$25
- Please allow 2 business days for claims to be processed

For Account Balance:
Go to www.NBSbenefits.com
or call (801) 838-7324 or (888) 353-9125

****Notice****
All over-the-counter (OTC) medication claims must be accompanied by a prescription to be eligible under new federal regulations

1 Personal Information

Employee Name _____	Company Name _____
Street Address, City, State, Zip _____	<input type="checkbox"/> No <input type="checkbox"/> Yes Address Change?
Phone Number _____	Social Security Number _____

2 Dependent Care Expenses

	Date of Service			Service Provider Tax ID# or SS#	Dependent's Name	Age	Amount
	MM	DD	YY				
1	_____	_____	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____	_____	_____
Total Dependent Care Expenses							_____

3 Health Care Expenses

	Date of Service			Office Visit	Rx	Dental	Vision	Non-Drug OTC	Orthodontia	Other Services: Please Specify	Person Receiving Service	Amount
	MM	DD	YY									
1	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
2	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
3	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
4	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
5	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
6	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
7	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
8	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
9	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Total Health Care Expenses											_____	

4 Employee Signature

I, the undersigned, attest that to the best of my knowledge these statements are complete and true. I authorize the release of any medical information to my spouse. I certify these expenses are for valid services provided on the dates indicated and will not be reimbursed or claimed under any other Plan or claimed as a tax deduction.

Employee Signature _____	Date _____
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Please fax, mail, or email your claim form and receipts to the following:
Mail: National Benefit Services, LLC, P.O. Box 6980, West Jordan, UT 84084
Fax: Salt Lake Area Fax: (801) 355-0928 • **Toll Free Fax:** (800) 478-1528
Email: claims@NBSbenefits.com (PDF, TIFF, or JPG files only)