

# Flexible Spending Account (FSA) Claim Form



<b>Personal Information</b>	Employee Name							Company Name					
	Street Address				City	State	Zip	Address Change? <input type="checkbox"/> No <input type="checkbox"/> Yes					
	Phone Number				Social Security Number				For Account Balance: Go to <a href="http://www.NBSbenefits.com">www.NBSbenefits.com</a> or call (801) 838-7324 or (888) 353-9125  Please allow 2 business days for claims to be processed				
	For Quick Claim Processing: <ul style="list-style-type: none"> <li>Fully complete &amp; sign this claim form</li> <li>Attach copies of supporting EOB, receipts, vouchers, bills, etc.</li> <li>All receipts must detail each of the items summarized below</li> <li>Please print in dark blue or black ink when using this form</li> <li>Minimum Total Reimbursement \$25</li> </ul>												
<b>Dependent Care Expenses</b>	Date of Service MM DD YY			Service Provider Tax ID# or SS#			Dependant's Name			Age	Amount		
	1												
	2												
	3												
	<b>Total Dependent Care Expenses</b>												
<b>Health Care Expenses</b>  (Please list one expense per line)  **Notice** All over-the-counter (OTC) medication claims must be accompanied by a prescription to be eligible under new federal regulations	Date of Service MM DD YY			Office Visit	Rx	Dental	Vision	Non-Drug OTC	Ortho dontia	Other Services: Please Specify	Person Receiving Service	Amount	
	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"/>				
<b>Total FSA Health Expenses</b>													
<b>Employee Signature</b>	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			

Welfare-506 (07/2011)

**Please fax or mail 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](mailto:claims@NBSbenefits.com) (PDF, TIFF, or JPG files only)