

Health Care Expense Claim Form

Flexible Spending Account

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 Phone: 781-848-9848
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Plan Year: _____

Participant Name: _____

Employer: _____

Mailing Address: _____

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

City, State, Zip: _____

Participant Daytime Phone: _____

Check if New Address _____

Email: _____

List Unreimbursed Medical Expenses by Classification <i>(Participants and IRS Eligible Dependents)</i>	Dates of Service		Amount (\$)
	MM/DD/YYYY		
	START	END	
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 and funds are typically in your account by the end of the week; however, the bank has 3 business days to post it to your account.
- Checks are mailed bi-weekly.
- Expenses must be incurred during the plan year or before the termination date of employment to be reimbursed.
- Claims received by Monday are typically 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

<p>BABY/CHILD TO AGE 13</p> <ul style="list-style-type: none"> <input type="checkbox"/> Lactation Consultant* <input type="checkbox"/> Lead-Based Paint Removal <input type="checkbox"/> Special Formula* <input type="checkbox"/> Tuition: Special School/Teacher for Disability or Learning Disability* <input type="checkbox"/> Well Baby /Well Child Care <p>DENTAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dental X-Rays <input type="checkbox"/> Dentures and Bridges <input type="checkbox"/> Exams and Teeth Cleaning <input type="checkbox"/> Extractions and Fillings <input type="checkbox"/> Oral Surgery <input type="checkbox"/> Orthodontia (reimbursable after payment) <input type="checkbox"/> Periodontal Services <p>EYES</p> <ul style="list-style-type: none"> <input type="checkbox"/> Eye Exams <input type="checkbox"/> Eyeglasses and Contact Lenses <input type="checkbox"/> Laser Eye Surgeries <input type="checkbox"/> Prescription Sunglasses <input type="checkbox"/> Radial Keratotomy <p>HEARING</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hearing Aids and Batteries <input type="checkbox"/> Hearing Exams <p>LAB EXAMS/TESTS</p> <ul style="list-style-type: none"> <input type="checkbox"/> Blood Tests and Metabolism Tests <input type="checkbox"/> Body Scans <input type="checkbox"/> Cardiograms <input type="checkbox"/> Laboratory Fees <input type="checkbox"/> X-Rays 	<p>MEDICAL EQUIPMENT/SUPPLIES</p> <ul style="list-style-type: none"> <input type="checkbox"/> Air Purification Equipment* <input type="checkbox"/> Arches and Orthotic Inserts <input type="checkbox"/> Contraceptive Devices <input type="checkbox"/> Crutches, Walkers, Wheel Chairs <input type="checkbox"/> Exercise Equipment* <input type="checkbox"/> Hospital Beds* <input type="checkbox"/> Mattresses* <input type="checkbox"/> Medic Alert Bracelet or Necklace <input type="checkbox"/> Nebulizers <input type="checkbox"/> Orthopedic Shoes* <input type="checkbox"/> Oxygen* <input type="checkbox"/> Post-Mastectomy Clothing <input type="checkbox"/> Prosthetics <input type="checkbox"/> Syringes <input type="checkbox"/> Wigs* <p>MEDICAL PROCEDURES/SERVICES</p> <ul style="list-style-type: none"> <input type="checkbox"/> Acupuncture <input type="checkbox"/> Alcohol and Drug/Substance Abuse (inpatient treatment and outpatient care) <input type="checkbox"/> Ambulance <input type="checkbox"/> Fertility Enhancement and Treatment <input type="checkbox"/> Hair Loss Treatment* <input type="checkbox"/> Hospital Services <input type="checkbox"/> Immunization <input type="checkbox"/> In Vitro Fertilization <input type="checkbox"/> Physical Examination (not employment-related) <input type="checkbox"/> Reconstructive Surgery (due to a congenital defect, accident, or medical treatment) <input type="checkbox"/> Service Animals <input type="checkbox"/> Sterilization/Sterilization Reversal <input type="checkbox"/> Transplants (including organ donor) <input type="checkbox"/> Transportation to Medical Facility 	<p>MEDICATIONS</p> <ul style="list-style-type: none"> <input type="checkbox"/> Insulin <input type="checkbox"/> Prescription Drugs <p>OBSTETRICS</p> <ul style="list-style-type: none"> <input type="checkbox"/> Doulas* <input type="checkbox"/> Lamaze Class <input type="checkbox"/> OB/GYN Exams <input type="checkbox"/> OB/GYN Prepaid Maternity Fees (reimbursable after date of birth) <input type="checkbox"/> Pre- and Postnatal Treatments <p>PRACTITIONERS</p> <ul style="list-style-type: none"> <input type="checkbox"/> Allergist <input type="checkbox"/> Chiropractor <input type="checkbox"/> Christian Science Practitioner <input type="checkbox"/> Dermatologist <input type="checkbox"/> Homeopath <input type="checkbox"/> Naturopath* <input type="checkbox"/> Optometrist <input type="checkbox"/> Osteopath <input type="checkbox"/> Physician <input type="checkbox"/> Psychiatrist or Psychologist <p>THERAPY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Alcohol and Drug Addiction <input type="checkbox"/> Counseling (not marital or career) <input type="checkbox"/> Exercise Programs* <input type="checkbox"/> Hypnosis* <input type="checkbox"/> Massage* <input type="checkbox"/> Occupational <input type="checkbox"/> Physical <input type="checkbox"/> Smoking Cessation Programs* <input type="checkbox"/> Speech <input type="checkbox"/> Weight Loss Programs*
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Please Note: **The IRS will not allow 'OTC medicines or drugs' to be purchased with Health Care FSA or HRA funds unless accompanied by a prescription.** The following is a high level list of Over-the-Counter (OTC) items that clearly are not medicine or drugs and **are eligible** for purchase with Health Care FSA Plans.

<p>Antiseptics, Wound Cleansers</p> <ul style="list-style-type: none"> <input type="checkbox"/> Alcohol, peroxide, Epsom salt, <p>Baby Electrolytes</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pedialyte, Enfalyte <p>Denture Adhesives, Repair, and Cleansers</p> <ul style="list-style-type: none"> <input type="checkbox"/> PoliGrip, Benzodent, Efferdent <p>Diabetes Testing and Aids</p> <ul style="list-style-type: none"> <input type="checkbox"/> Insulin, Ascencia, One Touch, Diabetic Tussin, insulin syringes; glucose products 	<p>Diagnostic Products</p> <ul style="list-style-type: none"> <input type="checkbox"/> Thermometers, blood pressure monitors, cholesterol testing <p>Elastics/Athletic Treatments</p> <ul style="list-style-type: none"> <input type="checkbox"/> ACE, Futuro, elastic bandages, braces, hot/cold therapy, orthopedic supports, rib belts <p>Eye Care</p> <ul style="list-style-type: none"> <input type="checkbox"/> Contact lens care <p>Family Planning</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pregnancy and ovulation kits 	<p>First Aid Dressings and Supplies</p> <ul style="list-style-type: none"> <input type="checkbox"/> Band Aid, 3M Nexcare, non-sport tapes <p>Hearing Aid/Medical Batteries</p> <p>Incontinence Products</p> <ul style="list-style-type: none"> <input type="checkbox"/> Attends, Depend, GoodNites for juvenile incontinence <p>Reading Glasses and Maintenance Accessories</p>
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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.*