

Health FSA

CONFIDENTIAL INFORMATION

Health Care Flexible Spending Account Reimbursement Request



AUDITOR USE ONLY - DATE RECEIVED

Employee Name: _____ Employee ID Number: _____

Dept: _____ Phone: _____ Email: _____

Address change – **ONLY** print current mailing address if this is a new address not previously reported to this program.

Street *(only required if address has changed)* _____ City / State _____ Zip Code _____

Note: See page 2 of form for instructions on how to complete the information required below and a description of the other information that **must** be submitted with your request. Please list each type of expense on a separate line in date order; use additional forms if necessary. **Submit the original to Auditor Payroll retain a copy for your records.**

SUMMARY OF EXPENSES

Name of person receiving service or supplies	Relationship to employee	Provider of service or supplies	Type of expense	Date of service	Total expense

Attach back up to claim and seal in confidential envelope to protect private health information.

Total _____

Protection of private health information is the responsibility of the participant until ACTTC-Payroll receives it.

Claim must total \$20 or more

I certify that, to the best of my knowledge, the above information is accurate and that payment is being requested only for eligible medical expenses of covered parties (self, spouse, or IRS Qualified dependents) and is not incurred for cosmetic or general health purposes. I am requesting payment only for expenses that have not, and will not, be paid by any other source. I certify that no other tax deduction will be taken for the above expenses.

Employee Signature: _____ Date: _____

Health FSA

Reimbursement Request Instructions Health Care Flexible Spending Account

Filling out the form

Please print and complete all sections of the form. Once you have completed the form, sign and date it. Submit the original; keep a copy for your records.

1. Submit only expenses that are reimbursable under the Health Care Flexible Spending Account Program. These include expenses **not paid** by any medical, dental, or vision insurance plan. Eligible expenses include:
 - Co-payments and deductibles (your share of the expenses)
 - Co-payments for eyeglasses, contact lenses, hearing aids, plus the cost of exams associated with their prescription
 - Most healthcare services or supplies that you could otherwise use as a tax deduction.
2. **Name of person receiving service or supplies** – Enter the first and last name of the person receiving service or supplies.
3. **Relationship to employee** – Indicate self, spouse, son, daughter, or other **IRS-qualified dependent**.
4. **Provider of services or supplies** – Enter the name of the doctor, dentist, ophthalmologist, hospital, clinic, pharmacy, etc., that provided the service.
5. **Type of expense** – Enter a description of the service or supplies for which reimbursement is requested, such as: routine physical, dental work, eye examination, eyeglasses, contacts, prescription drugs, doctor visit, dental exam, etc.
6. **Date of service** – Enter date that service or supplies were received. This date must occur during your participation in the plan. Expenses are considered incurred on the date services are provided.
7. **Total expense** – Enter the amount of the expense.
8. **Total** – Enter the total amount of attached bills/receipts.

NOTE: Claim must total \$20 or more.

If you need more forms or have questions about how to complete this form or what documentation to submit, call (707) 565-6024 or 565-4690.

Attaching your bills and records

When you submit your request for reimbursement, you must provide copies of itemized bills or receipts which **clearly** state each of the services or supplies provided, including:

- Name of person or organization providing the service or supplies
- Name of the person receiving the service or supplies
- Date that service or supplies were provided
- Total charge for the service or supplies
- Description of the service or supplies – bill for prescription drugs must include prescription number, date of purchase, and name of prescribing physician.

In addition, attach copies of third party insurance Explanation of Benefits (EOB) for all vision and dental expenses. EOB's from the applicable insurance plan are also required for medical expenses if the Sonoma County Health Plan covers the patient or if the patient is covered by any other insurance. EOB's must be submitted for any and all expenses that are covered by any insurance.

If there is double insurance coverage, **submit both** EOB's.

Submitting your request

Send the original copy of the completed form and all back up to:

ACTTC PAYROLL OFFICE
COUNTY OF SONOMA
575 ADMINISTRATION DRIVE, ROOM 117A
SANTA ROSA CA 95403-2815