bswift

Flexible Spending Account (FSA)
Request for Reimbursement Form

Participant Name (Last, First, MI)	Last 4 Digits of SS#	Employer Name	
Address	**New Address?**	**Phone Number**	**Email Address**
	☐ Yes ☐ No		

- **How to file your claim** – Join the growing number of participants who submit claims online for faster service through your benefits portal. Otherwise, file your claim via email, fax, or mail.
- **Claim processing time** – Claims will be processed within 2 business days after bswift receives your claim form, or as specified by your employer. You may check the status of your claim by logging into your benefits portal.

Health Care Flexible Spending Account Expenses

Follow the instructions on the back of this form to ensure correct documentation is submitted for prompt claims processing.

Date(s) of Service	Type of Expense (Office Visit, Dental, RX, etc.)	Provider of Service (Pharmacy, Dr. Smith, etc.)	Patient Name	Relationship to You	Amount Requested
					$
					$
					$
					$
					$
					$
					$
				Total	$

Dependent Care (Day Care) Flexible Spending Account Expenses

To be reimbursed, you must provide the dependent care provider's signature or an itemized statement from the provider. By submitting requests for future dates of service, I confirm that my payroll deductions are less than my daycare costs per week so recurring reimbursements will occur when payroll deductions post to my Dependent Care FSA.

Date(s) of Service	Name of Dependent	Age	Type of Dependent Care Service (Daycare, Day Camp, Preschool, etc.)	Amount Requested
				$
				$
				$
				$
			Total	$

Dependent Care Provider Certification:
I certify that I provided dependent care services as detailed above.
Provider Signature: _____

READ CAREFULLY: I certify that all expenses for which I am claiming reimbursement via this form were incurred by me, an eligible spouse, or an eligible dependent; that the expenses were incurred while I was covered under my employer's FSA plan and that they are eligible expenses under that plan; that the expenses have not been reimbursed nor will I seek reimbursement from any other source; and that I have not and will not claim these expenses as an income tax deduction or credit. I certify that any expenses claimed as dependent care expenses are work-related and were provided for my dependent under the age of 13 or for my dependent who is incapable of self-care. I understand that I must submit and retain sufficient documentation for any expenses for which I seek reimbursement. If additional information is needed regarding claims for expenses incurred by a dependent, my dependent has authorized me to respond to additional requests. To the best of my knowledge, the statements I have made on this form are complete and accurate.

Participant Signature: _____ **Date:** _____

How to File a Request for Reimbursement

IRS regulations require documentation to substantiate requests for reimbursement. The chart below lists the type of documentation that is needed in order to process your claim, depending on the type of claim submitted.
All documentation must be submitted along with a completed FSA request for reimbursement form.

If Covered By Insurance (Medical, Dental, Rx, Vision)	• Explanation of benefits (EOB) showing the amount that you owe. To obtain your EOB, follow these steps: 1. Have your provider submit the claim to your insurance carrier. 2. Your insurance carrier will then send you an EOB showing the amount for which you are responsible. ◊ *Tip: Register on your insurance carrier's website to obtain a copy of your EOB.*
If Not Covered By Insurance	• Itemized statement clearly showing: 1. Date service was provided (not the billing date or the date you paid for the service), 2. Provider name and address, 3. Patient name, 4. Description of services (diagnosis and procedure codes, eye exam, crown, etc.), and 5. Dollar amount for which you are responsible. ◊ *Tip: A simple receipt is not sufficient documentation, so make sure to ask your health care provider for an itemized statement.*
Prescriptions	• Pharmacy script or mail order statement showing patient name, name of prescription, date filled, and dollar amount; **OR** • Itemized printout from the pharmacy. ◊ *Tip: You may be able to register on your pharmacy's website to view your account and obtain an itemized list of prescriptions.*
Over-the-Counter Drugs and Medicines	• Cash register receipt showing the merchant name, date, product description, dollar amount paid; **AND** • Written prescription or medical necessity form from the patient's attending physician. Examples are antacids and digestive aids, allergy and sinus products, anti-gas and stomatch remedies, anti-itch and insect bite treatments, lice treatment, cold or flu treatment, pain relief products, respiratory treatments, and sleep aids or sedatives. ◊ *Tip: Some pharmacy websites have FSA sections that list eligible expenses.*
Over-the-Counter Medical Items	• Cash register receipt showing the merchant name, date, product description, and the dollar amount paid. Examples are bandages, braces and supports, catheters, contact lens supplies, denture adhesives, diagnostic tests and monitors, elastic bandages and wraps, first aid kits, diabetic supplies, reading glasses, wheelchairs, and canes. ◊ *Tip: Some pharmacy websites have FSA sections that list eligible expenses.*
Orthodontia	• Orthodontia contract from the orthodontist that includes a breakdown of the initial fee, estimated insurance payment, initial start date, duration of treatment, down payment amount, and monthly payments; **AND** • An itemized statement or receipt from the orthodontist showing the monthly amount and that it was paid. The orthodontia contact is only needed with your first orthodontia claim. The itemized statement or receipt must show the monthly charge consistent with the original orthodontic contract. ◊ *Tip: Future dates of service cannot be submitted. IRS guidelines require services to be incurred before you can be reimbursed.*
Dependent Care (Daycare)	• Provider signature on the request for reimbursement form; **OR** • Itemized receipt from the provider showing provider name and address, dates of service, name of dependent for whom the care was provided, and dollar amount owed. ◊ *Tip: The amount of reimbursement cannot exceed your current balance. Services must be provided before payment is made.*
	Examples of documentation that will not support your reimbursement request are: ▪ Cancelled checks ▪ Credit card statements ▪ Receipts that are not itemized ▪ Statements that say "balance forward", "previous balance" or "paid on account" ▪ Pre-treatment estimates of services ▪ Statements that do not include dates of service, description of services, patient name, provider information, and amount charged Important reminders: ▪ Follow the guidelines above to ensure your claim is processed as quickly as possible. ▪ Keep a copy of the documentation you submit. ▪ Make sure to sign your form. ▪ A comprehensive list of eligible expenses is available on your benefits portal under Health Care Expense Table.