



Flexible Spending Account Health Care Reimbursement

PREPARING YOUR CLAIM FORM

- Complete Sections 1 and 2.
- Complete Sections 3 and 4 as applicable (list and separate expenses by individual family members).
- Complete Sections 5 and 6.
- Attach the appropriate documentation indicated below:

Explanation Of Benefits (EOB) – for expenses partially covered by your medical/dental insurance plan. If insurance is available, you must submit your EOB with your completed claim form.

Copay receipt from the doctor/dentist/pharmacist if this is your only expense.

Itemized bill or statement from the doctor/dentist/pharmacist/health care professional when expenses are not covered by your medical/dental plan which includes:

- Name & address of the doctor/dentist/pharmacist/health care professional
- Patient's name
- Dates of service
- Type of service
- Dollar amount charged

A canceled check is not adequate documentation.

SUBMITTING YOUR CLAIM

- Retain copies for your files. Claim information can not be returned.
- Send completed form and documentation to:

Aetna FSA
P.O. Box 4000
Richmond, KY 40476-4000
Fax to: 1-888-238-3539 (1-888-AET-FLEX)

- If you have questions about a Flexible Spending Account claim, call the toll-free number of the Aetna Life Insurance Company claim center listed above.

For the hearing impaired, call **1-877-703-5572 TDD/TTY**.

Aetna's Voice Advantage® Unit (AVA) also is available to provide instant account balance and claim payment information Monday through Saturday from 7 a.m. to 12 midnight ET, and can be accessed through the service center toll-free number.

[Important Note] If you are submitting a claim with a change in your mailing address, you must notify your employer to make the change on your FSA enrollment file to avoid misdirected claim payments.

1. Employee Information	Identification Number	Name	Daytime Telephone Number ()	
	Address (include zip code) <input type="checkbox"/> Check if address is new		Home Telephone Number ()	
2. Employer Information	Employer Name			FSA Control Number
3. Expense Information	Name	Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Date of Birth (MM/DD/YYYY)	Age
	Date(s) of Service (MM/DD/YYYY) From _____ Thru _____		Total Amount Submitted \$ _____	
	Name	Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Date of Birth (MM/DD/YYYY)	Age
	Date(s) of Service (MM/DD/YYYY) From _____ Thru _____		Total Amount Submitted \$ _____	
	Name	Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Date of Birth (MM/DD/YYYY)	Age
	Date(s) of Service (MM/DD/YYYY) From _____ Thru _____		Total Amount Submitted \$ _____	
4. Orthodontia Expenses	Name	Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Date of Birth (MM/DD/YYYY)	Age
	Date(s) of Service (MM/DD/YYYY) From _____ Thru _____		Total Amount Submitted \$ _____	
	PRE-PAID SERVICES -- <u>Expenses partially covered by insurance</u> – pre-paid expenses are reimbursable for the <u>monthly</u> payment amount that exceeds the paid insurance portion on the (EOB). Requests for reimbursement should not exceed expenses associated with services incurred during the current plan year. <u>No insurance coverage</u> – pre-paid expenses are reimbursable for the component of the expense related to services incurred during the current enrolled plan year. Requests for subsequent plan years must be resubmitted.			
5. Coordination of Benefits (COB)	Are you or any family members for which you are requesting reimbursement eligible to receive benefits under any medical, dental, prescription or vision plan other than your primary coverage? <input type="checkbox"/> Yes If yes, you must include a copy of your EOB. <input type="checkbox"/> No If no, you must include an itemized statement.			
6. Employee Certification	I certify that all expenses for which reimbursement is claimed from the Flexible Spending Account have been incurred and have not been reimbursed and are not reimbursable under any other health plan coverage (including a Health Savings Account [HSA] that I or my spouse maintain). (I understand that special rules apply in the event that I have both a Health Savings Account and a Flexible Spending Account, and I have submitted this claim in accordance with the relevant terms of my benefits plan and the applicable provisions of federal tax law.) I understand that I am required to submit, in addition to this claim form, an invoice or other statement from health care professional (such as a physician, dentist or pharmacy) or other independent third party stating that the medical expenses have been incurred and the amount of such expense. I certify that any claims for orthodontia expenses comply with the rules as stated in paragraph four above. I represent that any individual (other than the employee or the employee's spouse) for whom a claim is filed hereunder qualifies as a dependent of the employee for federal income tax purposes. I further declare that I have not and will not deduct these expenses on my federal, state or local income tax returns.			
Sign Here ►	Employee Signature _____			Date _____
Any person who knowingly and with intent to defraud files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime.				