Kereon HSA
"Guiding You To Better Health"

FLEXIBLE SPENDING ACCOUNT (FSA) CLAIM FORM

Employer Name:		**E-mail (Opt.):**	
Employee Name:		**SSN#:**	**XXX-XX-_____**
Employee Address:		**PHONE:**	**( )**

Please send reimbursement to me as follows: ☐ Check ☐ Deposit into Bank Account on file

☐ **New** or **Changed** Banking Information

Bank name: _____ Routing # _____ Acct #_____

Description of Claim Submission
This information must be completed

Date of Service MM/DD/YY	Patient Name	Relationship	Name of Provider	Description of Service	Claim Amount
					$
					$
					$
					$
					$
					$
					$
				Total:	$

DEPENDENT CARE (Day Care) CLAIMS

Date of Service From	To	Dependent Name	Age	Dependent Care Provider Name	Dependent Care Provider Address	Provider Tax Id#/SS#	Claim Amount
							$
							$
							$
						Total:	$

TRANSPORTATION/MILEAGE CLAIMS

Date of Service From	To	Dependent Name	Destination/Description	Number of Miles	X .17 per mile Subject to change	OR Gas $	Tolls & Parking	Claim Amount
								$
								$

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ Date: _____ /_____ /_____

Send completed Claim Form & Supporting Documentation via Fax at: 952-449-3619
By mail: Kereon HSA, 1161 Wayzata Blvd. East, #184, Wayzata MN 55391
Or via Email: Claims.kereon@KereonHSA.com

1/1/17