# FLEXIBLE SPENDING ACCOUNT (FSA) CLAIM FORM

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|---|---|---|---|
| **Employer Name:** | | **E-mail:** | |
| **Employee Name:** | | **SS#:** | |
| **Employee Address:** | | **PHONE:** | ( ) |

☐ **Please check if this is a new address, phone number or Email address**

## Description of Claim Submission
## ***This information must be completed***

| Date of Service MM/DD/YY | Patient Name | Patient's SS# | 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 .27 per mile | 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: 763-383-4880**
**Or by mail: Kereon HSA, 13700 Watertower Circle., Suite D, Plymouth, MN 55441**