FSA REIMBURSEMENT CLAIM FORM

Please complete this form to request reimbursement of expenses incurred by you and/or eligible dependents. Itemized documentation of each expense must be provided. For questions, contact Customer Care at 1-844-786-3947.

PARTICIPANT INFORMATION *(to be completed by participant)*	
Participant Name:	
Employer Name:	
Employee Number/ID:	
Email Address:	
Home Address:	

Please list each eligible expense below:

Under the **Benefit Type** column, select one of the following benefit codes for each expense.

FSA – Health FSA **LPFSA -** Limited Purpose Health FSA **DCA –** Dependent Care Account **TRN** – Transit
PKG – Parking **DVFSA** – Dental/Vision Health FSA **PRA** – Premium Reimbursement Arrangement

Under the **Service Code** column, select one of the following service codes.

MT – Mass Transit **PK** – Parking **MD** – Medical **RX** – Prescription Drugs
OT – Over-the-Counter **VS** – Vision **DN** – Dental **IP** – Individual Premiums

Paid with TASC Card	Benefit Type	Date of service	Service Code	Service Provider	Dollar Amount

For quick reimbursement, file online via your employee portal or Mobile App!

Submit your claim form with supporting documentation via FAX to 877-231-1287.

To the best of my knowledge and belief, my statements on this Request for Reimbursement are complete and true. I am requesting reimbursement only for eligible expenses incurred during the applicable Plan Year and for eligible Plan Participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I understand that the IRS regulates my FlexSystem account and that these guidelines are implemented as a means of ensuring compliance and approval for reimbursement. I further understand that it is my responsibility to comply with these guidelines and to avoid submitting duplicate or ineligible requests, as doing so may delay payment. I authorize my Flexible Spending Account balance to be reduced by the amount requested.

Signature of Plan Participant **Date**

Please fax or mail completed forms to:

Total Administrative Services Corp (TASC) • PO Box 7511 • Madison, WI 53707-7511
Phone: 844-786-3947 • Fax: 877-231-1287