Reimbursement Form for Flexible Spending Account (FSA)

Note: You will need this form when submitting for reimbursement. Please make copies. This form can also be downloaded at http://cds.healthplan.org

EMPLOYEE INFORMATION		
Last:	First:	Middle:
Phone:	Your Employer:	
Member ID:	Email:	

Step 1. Complete the reimbursement form for eligible expenses incurred during your FSA plan year. When appropriate, health care expenses should be processed by your insurance company first. An expense is incurred when the service is provided, not when you are billed or pay for the service. Appropriate documentation must be included to process your reimbursement.

HEALTH CARE EXPENSES			
Date of Service	Type of Service	Provider of Service	Reimbursement Amount
		Total Reimbursement Requested:	

PARKING AND OR DEPENDENT CARE EXPENSES			
Date of Service	Provider of Service	Tax ID or SSN	Reimbursement Amount
		Total Reimbursement Requested:	

You may submit one reimbursement form for multiple service dates. For dependent care, we will reimburse up to the amount you have deposited in your account to date, minus any previous reimbursements.

To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for myself and/or my legal dependent(s). I certify that these expenses have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction.

Your Signature: _____ Date: _____

Required to process

Step 2. **"Please keep your original documentation"**
Submit this entire form and **copies** of your receipts, EOBs or other documentation to:

Mail: The Health Plan-Account Processing
PO Box 953,
Charleston WV 25323-0953
Fax: 1.866.347.3643

Email: customersolutions@healthplan.org

Phone: 866.347.3640 | 304.347.3640

Change of Address

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