HEALTH CARE FSA CLAIM FORM

BAS
Benefit Allocation Systems

Mail or Fax To:
BAS
P.O. Box 62407
King of Prussia, PA 19406
FAX: 1.888.265.2144

MyEnroll.com

Please type or print legibly.

*** Required Fields**

EMPLOYEE'S NAME * FULL NAME _____	WORK PH # WORK EXT
* SOC. SEC. # * EMPLOYER	HOME PH #
EMPLOYEE'S STREET ADDRESS * CITY * STATE * ZIP	
DEPENDENT'S NAME FULL NAME _____	**DEPENDENT'S STATUS** ☐ HANDICAPPED
DATE OF BIRTH SOC. SEC. #	☐ FULL-TIME STUDENT

CLAIM EXPENSE INFORMATION

CLAIM YEAR [____]

* DATE OF SERVICE (MM/DD) FROM	TO	* HEALTH CARE PROVIDER'S NAME	DESCRIPTION OF SERVICES RECEIVED	CLAIM AMOUNT
			TOTAL =	

HEALTH CARE REIMBURSEMENT ACCOUNT CERTIFICATION

I certify that the expenses submitted herewith qualify for reimbursement as expenditures for medical care and not merely for general health purposes. The expenses have been incurred and paid by my spouse, my eligible dependent(s), or me and have not or will not be reimbursed from any other source. The expenses have not or will not be claimed as deductions in filing income tax returns.

X _____

SIGNATURE DATE

* Benefit Allocation Systems, Inc. / MyEnroll.com does not insure benefits under the health care flexible spending account plan. Your employer is solely responsible for determination of entitlement to, and payment of, any amounts due under the plan. Refer to the plan documents for more details.

Form BAS claimf_form_med_bw Ed. 09/2003

Benefit Allocation Systems
132 Ivy Lane, PO Box 62407, King of Prussia, PA 19406
T.800.945.5513 F.888.265.2144
www.BASusa.com

FLEXIBLE SPENDING ACCOUNTS

Employee instructions and information for completing this claim form.

1. Complete all employee information questions.
2. Complete all dependent information questions, if the claim expenses are for a dependent, (submit one claim form per dependent).
3. Indicate the dates of services rendered, name of provider along with a brief description of the services and the amount of reimbursement you are requesting.
4. When requesting reimbursement for medical expenses, a copy of the explanation of benefits provided by any insurer or claims processor must also be attached when coordination of benefits is involved.
5. Be sure to attach itemized receipts for all items claimed. Claims for all expenses without itemized receipts, other than over-the-counter medications, will be declined. If you are submitting claims for over-the-counter medications a receipt must be submitted and the over-the-counter medication(s) for which you seek reimbursement must be detailed on the claim form.
6. Once the form is completed, forward the form with the attached receipts to the above address.
7. The provisions of this plan reserve to the Administrator and the Claims Processor the right to reject requests for reimbursement which they believe are not supported by proper documentation or do not qualify as reimbursable expenses under this plan.
8. If you have any further questions regarding submitting your claims, please contact a BAS Benefits Counselor at 1-800-945-5513 or visit BAS at www.BASusa.com.

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