

Flexible Spending Account (FSA) Claim Form



Instructions For Quick Claim Processing:

- Fully complete & sign this claim form
- Attach copies of supporting EOB, receipts, vouchers, bills, etc.
- All receipts must detail each of the items summarized below
- Please list one expense per line
- Please print in dark blue or black ink when using this form
- Minimum Total Reimbursement = \$25
- Please allow 2 business days for claims to be processed

For Account Balance:
Go to www.NBSbenefits.com
or call (801) 838-7324 or (888) 353-9125

****Notice****
All over-the-counter (OTC) medication claims must be accompanied by a prescription to be eligible under new federal regulations

1 Personal Information

| | |
|--|---|
| Employee Name _____ | Company Name _____ |
| Street Address, City, State, Zip _____ | <input type="checkbox"/> No <input type="checkbox"/> Yes Address Change? |
| Phone Number _____ | Social Security Number _____ |

2 Dependent Care Expenses

| | Date of Service | | | Service Provider Tax ID# or SS# | Dependent's Name | Age | Amount |
|--------------------------------------|-----------------|-------|-------|---------------------------------|------------------|-------|--------|
| | MM | DD | YY | | | | |
| 1 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 2 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 3 | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| Total Dependent Care Expenses | | | | | | | _____ |

3 Health Care Expenses

| | Date of Service | | | Office Visit | Rx | Dental | Vision | Non-Drug OTC | Orthodontia | Other Services: Please Specify | Person Receiving Service | Amount |
|-----------------------------------|-----------------|-------|-------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------------|--------------------------|--------|
| | MM | DD | YY | | | | | | | | | |
| 1 | _____ | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | _____ |
| 2 | _____ | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | _____ |
| 3 | _____ | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | _____ |
| 4 | _____ | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | _____ |
| 5 | _____ | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | _____ |
| 6 | _____ | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | _____ |
| 7 | _____ | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | _____ |
| 8 | _____ | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | _____ |
| 9 | _____ | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | _____ |
| Total Health Care Expenses | | | | | | | | | | | _____ | |

4 Employee Signature

I, the undersigned, attest that to the best of my knowledge these statements are complete and true. I authorize the release of any medical information to my spouse. I certify these expenses are for valid services provided on the dates indicated and will not be reimbursed or claimed under any other Plan or claimed as a tax deduction.

| | |
|--------------------------|------------|
| Employee Signature _____ | Date _____ |
|--------------------------|------------|

Please fax, mail, or email your claim form and receipts to the following:
Mail: National Benefit Services, LLC, P.O. Box 6980, West Jordan, UT 84084
Fax: Salt Lake Area Fax: (801) 355-0928 • **Toll Free Fax:** (800) 478-1528
Email: claims@NBSbenefits.com (PDF, TIFF, or JPG files only)