

FLEXIBLE SPENDING ACCOUNT CLAIM FORM

2. 3. 4.	Toda	ıy's Date:		# C	# of pages:		Plan Year: 20	
Employee Address:			☐ New Claim		Response	to Claim Denial		
Social Security Number or Work Phone: () Home Phone: ()	Employee Name:				Employer Name/Division Name:			
*Minimum check reimbursement is \$25; minimum reimbursement for direct deposit is .50 Medical Expense Reimbursement Account	Emp	loyee Address:	☐ Please check if c	hange of a	ddress; yo	u must also change wit	h your HR department.	
Medical Expense Reimbursement Account Total Amount Requested:				Phone: ()	Home Phon	Home Phone: ()	
Dependent Care Reimbursement Account Total Amount Requested: Dependent Care Provider Signature: X								
Note: you MUST include the provider Tax ID Number in the service provider column in the table below. If you use the account to pay for the cost of a babysitter, you must provide the babysitter's Social Security Number. If you cannot remit a copy of your bill/contract, your daycare provider must sign on the line below in lieu of submitting a receipt. Individual Premium Reimbursement Account *For reimbursement from this account please attach proof of the non-employer sponsored policy. Adoption Assistance Account Total Amount Requested: Type of Service Service Provider/ Rx Number	_							
Note: you MUST include the provider Tax ID Number in the service provider column in the table below. If you use the account to pay for the cost of a babysitter, you must provide the babysitter's Social Security Number. If you cannot remit a copy of your bill/contract, your daycare provider must sign on the line below in lieu of submitting a receipt. Individual Premium Reimbursement Account *For reimbursement from this account please attach proof of the non-employer sponsored policy. Adoption Assistance Account Total Amount Requested: Type of Service Service Provider/ Rx Number	De	pendent Care	Provider Signature:	X		D	ate:/	
*For reimbursement from this account please attach proof of the non-employer sponsored policy. Adoption Assistance Account Total Amount Requested:		account to pay for the cost of a babysitter, you must provide the babysitter's Social Security Number. If you cannot remit a						
Date of Service or D ependent Requested (R _x , co-pay, dental expense, etc.) 1.								
Service or D ependent Requested (R _x , co-pay, dental expense, etc.) 1. 2. 3. 4. 5. I certify that the above listed expenses have been incurred by me or by my spouse or dependent(s) and that they have not been		Adoption Assistance Account Total Amount Requested:						
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3. 4. 5. I certify that the above listed expenses have been incurred by me or by my spouse or dependent(s) and that they have not been	1.							
4. 5. I certify that the above listed expenses have been incurred by me or by my spouse or dependent(s) and that they have not been	2.							
5. I certify that the above listed expenses have been incurred by me or by my spouse or dependent(s) and that they have not been	3.							
I certify that the above listed expenses have been incurred by me or by my spouse or dependent(s) and that they have not been	4.							
	5.							
Employee's Signature: Date:/	Empl	oyee's Signatur	e:			Date:		

Revised 4/16/2014

P&A GROUP EST. 1975

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Claim Submission Guidelines

- Please number each receipt according to its order of appearance on this form.
- IRS guidelines do <u>not</u> consider cancelled checks as valid documentation.
- Previous balances are <u>not</u> acceptable.
- All reimbursements will be made payable to the employee.

Send completed claims via fax or mail to P&A Group.

FAX: Toll-free (877) 855-7105 or (716) 855-7105

Mail: Flex Department

17 Court Street, Suite 500 Buffalo, NY 14202-3204

P&A Group Customer Service Information

Customer service representatives are available Monday- Friday, 8:30 AM- 8:00 PM ET.

WEBSITE: www.padmin.com TOLL-FREE: (800) 688-2611

Electronic Claim Submission!

Upload and submit your claims directly to the P&A website from your mobile device or computer. Log into your P&A account for more information.

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