Health Care Flexible Spending Account is a division of the Office of Labor Relations' Pre-Tax Benefits Program

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA)
CLAIMS FORM

40 Rector Street, 3rd Floor, New York, NY 10006
Tel: (212) 306-7760 TTY: (212) 306-7629
nyc.gov/html/olr

HCFSA

1) IMPORTANT INSTRUCTIONS AND INFORMATION

1. A "Plan Year" is the calendar year, or for a newly eligible employee, any remaining portion thereof.
2. Reimbursements can only be made for expenses resulting from services that have been performed in the applicable Plan Year, but if dates of service for which you are seeking reimbursement begin in one Plan Year and end in the next Plan Year, a claims form for each Plan Year is required. No reimbursement can be made prior to services being performed.
3. You may submit up to 12 claims per month. Only claims received by the close of the month will be processed for that month. Once your claims are approved, you will receive a reimbursement check at the end of the following month.
4. The minimum reimbursement amount requested must total $50, unless your current account balance is less than $50, in which case your claim must equal or exceed the amount actually available.
5. The deadline to submit **all** claims is the last day of the Plan Year (December 31st). You should submit your claims in a timely fashion, however, you will have a grace period until **March 31st** following the close of the Plan Year to submit claims for services performed during the previous Plan Year. Claims received after March 31st will **not** be processed.
6. **Any unclaimed year-end balance in your account may not be carried to the next Plan Year and will be forfeited.**
7. Attach the Explanation of Benefits (EOB) statement from your health insurance carrier(s) for medical expenses (i.e., deductibles, co-payments) and the EOB from your Welfare Fund for dental, vision and/or hearing expenses. Also attach an itemized bill or receipt from your provider(s) for all eligible expenses. The date(s) of service on the claims form must match the date(s) of service on the EOB statement and the receipt or billing statement.

   Each EOB and bill, receipt or claims form must contain the following information (CANCELLED CHECKS ARE NOT ACCEPTABLE):

   - Name of person receiving service
   - Type of service
   - Date(s) of service
   - Amount charged for service
   - Name of provider rendering service

   The HCFSA Program reserves the right to request additional documentation.
8. Attach an itemized bill or receipt for over-the-counter drug claims and a prescription receipt for prescription drug claims.
9. **Definitions**:

   a) **Eligible Medical Expense:** An expense which has been incurred by the participant for qualifying health care expenses provided for an eligible health care recipient on or after the benefit effective date and which is eligible for reimbursement pursuant to the terms of the HCFSA Program.

   b) **Qualifying Health Care Expense:** An expense incurred for an eligible medical service which is: (i) performed in regard to an eligible health care recipient; (ii) not reimbursable by health insurance carrier and/or Welfare Fund; and (iii) not for the payment of health insurance premiums.

   Note: Any expense defined by the IRS as a non-deductible expense for income tax purposes shall be ineligible for reimbursement under HCFSA. Furthermore, an expense deductible for income tax purposes does not necessarily mean that it qualifies for reimbursement under this program.

   c) **Eligible Health Care Recipient:** The person must be eligible to be covered by the participant's employer's medical plan and must be either: (i) the participant; (ii) the participant's spouse; or (iii) a dependent of the participant. (**Note:** Domestic partners are not eligible health care recipients.)
10. Be sure to sign and date this form. Return your completed form and proper documentation to the address shown above. You may obtain additional claims forms on the FSA Web site at nyc.gov/html/olr.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA)

2) EMPLOYEE (PARTICIPANT) INFORMATION (Please type or print clearly.)

Last Name:	First Name:	M.I.:	Social Security Number:

☐ **Check here if this is a new address**

Home Address - Number and Street:	Apt. No.:	City:	State:	Zip Code:

Agency Name (Not Division):	Home Phone Number (Area Code):	Work Phone Number (Area Code):
	( )	( )

3) REIMBURSEMENT REQUESTS

Please read Important Instructions and Information on the reverse side before completing this form and refer to your enrollment information for HCFSA rules and regulations. If the service was provided for more than one day, show the beginning date and the ending date of the service.

	Name of Claimant:	Type of Service:	Date(s) of Service:	Reimbursement Requested:
1.			/ / to / /	$
	Provider's Name and Address:			
2.			/ / to / /	$
	Provider's Name and Address:			
3.			/ / to / /	$
	Provider's Name and Address:			
4.			/ / to / /	$
	Provider's Name and Address:			
5.			/ / to / /	$
	Provider's Name and Address:			

Total Reimbursement Amount Requested (1 + 2 + 3 + 4 + 5): $ _____

4) EMPLOYEE (PARTICIPANT) SIGNATURE

The above is a true and accurate statement of unreimbursed health care expenses incurred by me and/or my eligible dependent(s) on the date(s) indicated. I certify that I and/or my eligible dependent(s) have incurred these expenses and have not been previously reimbursed and are not eligible for reimbursement through any other plan. I understand that expenses reimbursed herein cannot be deducted from my or anyone else's individual Federal Income Tax return. All claims submitted by me comply with the rules and definitions set forth on the reverse side of this form. I understand that the Internal Revenue Code and the Plan Document are the final authority in determining eligible expenses.

Signature: _____ **Date:** _____

Did you remember to:

- ✓ **Complete the form?**
- ✓ **Sign and date the form?**
- ✓ **Attach an EOB statement, bills and appropriate documentation?**