HealthTrust

# Healthcare Flexible Spending Account
# Dependent Care Reimbursement Account
# REIMBURSEMENT FORM

*(Please see instructions on reverse side)*

**EMPLOYEE INFORMATION**

Employer _____ Plan Year _____

Employee Name _____

Address _____
Street Town/City State Zip

**PART 1 - HEALTHCARE FSA EXPENSES**

| Name of Individual Receiving Service | Relationship (e.g., spouse, son, daughter) | Date Service Provided | Description of Service (name of provider) | Amount |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | **Healthcare Expenses Subtotal** | **$** |

**PART 2 - DEPENDENT CARE REIMBURSEMENT ACCOUNT EXPENSES**

| Dependent's Name | Date of Birth | Date Service Provided | Provider Name (include Tax ID#) | Amount |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | **Dependent Care Expenses Subtotal** | **$** |

**TOTAL:** _____

You may request that your dependent care provider complete the below Dependent Care Provider's Certification, OR attach a copy of a receipt that includes the provider's name, dates of service, service rendered, and total charge.

**DEPENDENT CARE PROVIDER'S CERTIFICATION OF SERVICES RENDERED**

I, the signer below, certify that the services listed in Part 2 were rendered by me and charges incurred have been paid for.

| Provider's Name: | Provider's Address: | |
|---|---|---|
| Provider's Tax ID#: | Provider's Signature: | Date: |

**EMPLOYEE CERTIFICATION**

I certify that any expenses for which I am requesting reimbursement from my Healthcare FSA, as itemized above, were incurred by me (and/or my spouse and/or eligible dependents) for medical care as permitted under IRS rules and the Healthcare FSA, and have not been, and will not be, reimbursed by any other plan.

I certify that any expenses for which I am requesting reimbursement from my Dependent Care Reimbursement Account, as itemized above, were incurred by me (and/or my spouse) for dependent care as permitted under IRS rules and the Dependent Care Reimbursement Account, and have not been, and will not be, reimbursed by any other plan.

I understand that expenses reimbursed through the program cannot be used to claim any federal income tax deduction or credit. To the best of my knowledge and belief, my statements on this form are complete and true.

_____ _____
Employee Signature Date

**NOTE:** Signature and supporting information are required; incomplete reimbursement forms may be delayed or returned.

## INSTRUCTIONS

1. **Complete all applicable sections of this form and attach proof of expense that shows date incurred, amount you are responsible for, provider name and description of service.** Accepted as proof of expense are: itemized invoice, receipt of payment from provider or insurance, and Explanation of Benefits form. The receipt for prescription drugs should include the prescription name or NDC#, date the prescription was filled, patient name and cost. A receipt for an over-the-counter item must be a printed receipt that includes the name of the item (handwritten over-the-counter item names are unacceptable), the price and date purchased. The Dependent Care Provider's Certification of Services Rendered may be used as proof of expense. Canceled checks are not acceptable.

2. Your Healthcare FSA or Dependent Care Reimbursement Account may only be used to reimburse expenses incurred during the plan year (or during the 2½-month grace period immediately following the plan year if elected by your employer) for which an election is in force. An expense is incurred at the time a service is furnished and not when you are billed, charged for, or pay for the service.

3. Mail or fax the form, plus attachment(s), to HealthTrust at the address noted below. HealthTrust processes reimbursements on a weekly basis. Completed reimbursement forms that are received by the end of the day on Tuesday generally will be processed for reimbursement on Thursday. Incomplete reimbursement forms may be delayed or returned.

4. The amount available for reimbursement of Dependent Care expenses will not exceed the amount credited to your Dependent Care Reimbursement Account to that date, reduced by prior reimbursements for the same period of coverage. Any expenses claimed in excess of your account balance will be carried over and reimbursed when sufficient additional monies are credited to your account. Healthcare FSA reimbursements are paid in full, not to exceed the yearly total.

5. Dependent Care reimbursement requests must include the provider's name and Taxpayer ID or Social Security number.

6. Reimbursement requests may be submitted for up to 90 days after the plan year (or the 2 ½-month grace period) ends. Amounts not so claimed will be forfeited.

7. The minimum check amount for reimbursement is $20 unless it is for your last claim of the plan year.

8. A detailed list of eligible healthcare expenses is contained in the Plan Document, available from your employer, or by following the Flexible Account Spending link at ***www.healthtrustnh.org***.

### MAIL OR FAX COMPLETED FORM TO:

HealthTrust
Attn: FSA Reimbursement
PO Box 617
Concord, NH 03302

603.415.3099 (fax)