Health Care Flexible Spending Account (HCFSA) Program

2) EMPLOYEE (PARTICIPANT) INFORMATION (PLEASE TYPE OR PRINT CLEARLY)

LAST NAME	FIRST NAME	MI.	SOCIAL SECURITY NUMBER

HOME ADDRESS - NUMBER AND STREET ☐ *CHECK HERE IF THIS IS A NEW ADDRESS* | APT. NO.

CITY | STATE | ZIP CODE

HOME OR CELL (DAYTIME) PHONE NUMBER	WORK PHONE NUMBER	AGENCY NAME (NOT DIVISION)
( ) -	( ) -	

3) HCFSA REIMBURSEMENT REQUESTS

Please read "Instructions and Important 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. ***Each claim must be separated by patient, date/type of service and dollar amount.***

1

PATIENT LAST NAME | PATIENT FIRST NAME | MI.

DATE(S) OF SERVICE (MM/DD/YY) FROM _____/_____/_____ TO _____/_____/_____ | TYPES OF SERVICE ☐ Medical ☐ RX ☐ OTC ☐ Dental ☐ Vision | REIMBURSEMENT AMOUNT REQUESTED $

CLAIM PERIOD (CHECK ONLY ONE)
☐ 2017 Plan Year (services incurred 1/1/17 - 12/31/17) ☐ 2016 Plan Year (services incurred 1/1/16 - 12/31/16) ☐ 2016 Grace Period (services incurred 1/1/17 - 3/15/17 using 2016 balance)

PROVIDER'S NAME

PROVIDER'S ADDRESS - NUMBER AND STREET | APT. NO.

CITY | STATE | ZIP CODE

2

PATIENT LAST NAME | PATIENT FIRST NAME | MI.

DATE(S) OF SERVICE (MM/DD/YY) FROM _____/_____/_____ TO _____/_____/_____ | TYPES OF SERVICE ☐ Medical ☐ RX ☐ OTC ☐ Dental ☐ Vision | REIMBURSEMENT AMOUNT REQUESTED $

CLAIM PERIOD (CHECK ONLY ONE)
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PROVIDER'S NAME

PROVIDER'S ADDRESS - NUMBER AND STREET | APT. NO.

CITY | STATE | ZIP CODE

3

PATIENT LAST NAME | PATIENT FIRST NAME | MI.

DATE(S) OF SERVICE (MM/DD/YY) FROM _____/_____/_____ TO _____/_____/_____ | TYPES OF SERVICE ☐ Medical ☐ RX ☐ OTC ☐ Dental ☐ Vision | REIMBURSEMENT AMOUNT REQUESTED $

CLAIM PERIOD (CHECK ONLY ONE)
☐ 2017 Plan Year (services incurred 1/1/17 - 12/31/17) ☐ 2016 Plan Year (services incurred 1/1/16 - 12/31/16) ☐ 2016 Grace Period (services incurred 1/1/17 - 3/15/17 using 2016 balance)

PROVIDER'S NAME

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TOTAL REIMBURSEMENT AMOUNT REQUESTED (1+2+3) $_____

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 as set forth on the reverse side of this form. I understand that the Internal Revenue Code and the HCFSA Plan Document are the final authority in determining eligible expenses.

Signature _____ **Date** _____/_____/_____

Did you remember to: **✓ Complete all sections?** **✓ Choose the correct claim period?** **✓ Sign and date the form?** **✓ Attach EOB statement(s), bill(s) and appropriate documentation?**

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

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA) PROGRAM
CLAIMS FORM

Bowling Green Station, P.O. Box 707, New York, NY 10274
Tel: (212) 306-7760 TTY: (212) 306-7629 nyc.gov/fsa

HCFSA

1) INSTRUCTIONS AND IMPORTANT INFORMATION

1. A" Plan Year" is the calendar year (January 1-December 31) or for a newly eligible employee, any remaining portion thereof.

   A "Grace Period" is from January 1 through March 15 following the end of the current Plan Year. The HCFSA claim may be incurred during this period and reimbursed using the remaining balance from the participant's previous Plan Year's account.

   A "Claims Run-Out Period" is from January 1 through May 31 following the end of the current Plan Year, during which you may submit any outstanding or pending claims incurred during the Plan Year or the Grace Period. Claims received after May 31 will **not** be processed.

2. When submitting a claim either during the Grace Period or the current Plan Year, you should check the applicable box when completing your claim information. Please note that once a new Plan Year has begun, you may claim reimbursement with either the remaining balance in your previous Plan Year's account, or the new balance from the current Plan Year's account. Your reimbursement may also be divided between these two accounts.

3. **After the Claims Run-Out Period has ended, any unclaimed year-end balance in your account will not be carried into the next Plan Year and will be forfeited.**

4. Reimbursement can only be made for expenses resulting from services that have been received in the applicable Plan Year. No reimbursement can be made prior to services being received.

5. The minimum reimbursement amount requested must total $50.00, unless your current account balance is less than $50.00.

6. Only claims received by the close of the month will be processed for that month. Once your claims are approved, you will receive reimbursement at the end of the following month.

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 and the receipt or billing statement.

   Each EOB, bill, receipt or claims form must contain the following information:

   - Name of patient 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 a doctor's prescription and an itemized bill or receipt for over-the-counter (OTC) drug claims, or a copy of the product box containing the name of the OTC drug, if an itemized receipt is not available. You must attach 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 a 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 Recipients: (i) the participant, who is eligible to be covered under the City of New York Employee Health Benefits Program (EHBP); (ii) the participant's spouse, who is eligible to be covered under the City of New York EHBP; and (iii) the participant's children who are eligible for coverage under the City of New York EHBP, including the participant's adult children who do not attain age 27 by the end of the Plan Year.

   Note: Domestic partners/civil unions are not eligible health care recipients under HCFSA.

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 website at nyc.gov/fsa.