Camdenton R-III School District
Claim for Reimbursement
(FSA Plans)

Employee Name:_______________________ Social Security #: _____________________ Phone Number: ________________

Dependent Care Expense Claims (Adult or Child Day Care Expenses must be incurred prior to term date even if funds still available.)

Name of Dependents	Period Covered		Name, Address and Taxpayer Identification Number of Provider of Service	Amount Incurred
	From	To		
				$
				$
				$
			TOTAL DEPENDENT CARE EXPENSE:	$

For Dependent Care Expenses you may choose to have your dependent care provider sign and date below to certify the expenses were incurred in lieu of providing a separate dependent care receipt.		
I certify that the dependent care expenses shown are valid		
Dependent Care Provider Signature	**Dependent Care Provider ID**	**Date**

***NOTE**: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the plan year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of $200 if there is one (1) child or dependent, and $400 if there are two (2) or more.) No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes, or is your child or stepchild and is under age 19.

Unreimbursed Medical Expense Claims for FSA (Must be incurred prior to term date even if funds still available.)

If you have an HRA with Med-Pay, Inc., you <u>MUST</u> submit to your HRA PLAN first.

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount	Check here **ONLY** if the receipt attached is for **substantiation** of **Benny** Card Purchase
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
			TOTAL UNREIMBURSED MEDICAL EXPENSE:	$	

READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Company's Flexible Spending Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

____   ____

Employee's Signature   **Date**

<u>Return this claim form</u> with supporting documentation (EOBs, receipts, etc.) to FSA/HRA Claims Dept

Mail to: Med-Pay, Inc. ▪ PO Box 10909 ▪ Springfield, MO 65808

Fax to: (417) 841-4117 ▪ Scan and email to: flexcs@med-pay.com or flexclaims@med-pay.com

Create claim and upload scanned receipt to: https://hrbenefitsdirect.com/Med-Pay

Note: **Keep a copy of this form for future claims. Copy available on https://hrbenefitsdirect.com/Med-Pay.**