**FAX: 585-389-7003**

Submit or view claims **ONLINE: https://benefits.paychex.com**

**Paychex Employee Services: 877-244-1771, available 24/7**

FOR OFFICE USE ONLY

Docket # _____

PAYCHEX®

# Flexible Spending Account (FSA) Reimbursement Claim
# Unreimbursed Medical Expenses

**EMPLOYEE INFORMATION** (print)

Employee Name _____ Company Name _____

Social Security Number (last 4 digits) _____ Employee Telephone Number (___) _____ - _____

E-mail Address _____

Visit **https://benefits.paychex.com** at any time to submit claims **ONLINE** or learn the status of your claim.

All claim reimbursements will be processed within 2 business days upon receipt of the completed claim form and all supporting documentation.

**INSTRUCTIONS CHECKLIST:**

☐ Enclose copies of all itemized bills and/or receipts from your provider or a copy of your orthodontia services contract, if applicable. Use blue or black ink only to identify FSA items on receipts. **Do not use highlighter. Copies of personal checks, cancelled checks, or credit card receipts are not valid for verification of service.**

☐ Verify that bills and receipts contain:

- date of service
- description of service
- cost of service
- provider's name
- provider's address
- prescription name (if expense is for a prescription)*

*Over-the-counter (OTC) medicines and drugs (other than insulin) are no longer eligible for reimbursement under a medical flexible spending account **unless** prescribed by a medical practitioner.

☐ If you are currently funding a Health Savings Account (HSA) in addition to your FSA, your FSA is a limited purpose FSA and may only be used to pay for vision, dental, and preventative medical expenses.

☐ **Sign your claim form** and fax it to the number noted above. Retain a copy for your records.

☐ If you prefer, mail your claim to: Paychex, Inc., FSA Claims, PO Box 3000, Henrietta, NY 14467-3000.

| Claim | Name of Service Recipient | Relationship to Employee | Service Date(s) | Service Description | Service Provider | Amount |
|---|---|---|---|---|---|---|
| **SAMPLE** | John Doe | ☐ Self<br>☐ Spouse<br>☑ Dependent | 07/07/07 | ☑ Medical<br>☐ Dental<br>☐ Vision<br>☐ Pharmacy | Dr. Jones | $521.43 |
| **01** | | ☐ Self<br>☐ Spouse<br>☐ Dependent | | ☐ Medical<br>☐ Dental<br>☐ Vision<br>☐ Pharmacy | | $ |
| **02** | | ☐ Self<br>☐ Spouse<br>☐ Dependent | | ☐ Medical<br>☐ Dental<br>☐ Vision<br>☐ Pharmacy | | $ |
| **03** | | ☐ Self<br>☐ Spouse<br>☐ Dependent | | ☐ Medical<br>☐ Dental<br>☐ Vision<br>☐ Pharmacy | | $ |
| **04** | | ☐ Self<br>☐ Spouse<br>☐ Dependent | | ☐ Medical<br>☐ Dental<br>☐ Vision<br>☐ Pharmacy | | $ |
| | | | | | **TOTAL** | $ |

If you have more claims, please complete additional Reimbursement Claim forms.

**CLAIM INFORMATION**

I certify that the information here is true and correct; that the expenses incurred were for myself, my spouse as defined by federal law, or my eligible dependents; and that these expenses are not reimbursable under any other health plan coverage.

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