



MEDICAL / DEPENDENT CARE EXPENSES
Flexible Spending Accounts Plan
CLAIM FORM

1. Instructions: *(incomplete claim forms will not be processed)*

- ◆ Complete the Employee Information requested under Section 2.
- ◆ Complete Section 3 and attach an itemized bill from the Provider.
- ◆ Read the Employee Authorization carefully and sign under Section 4.
- ◆ Keep complete copies of everything submitted to EBS for your records.
- ◆ Completed Claim Forms should be mailed or faxed to:

Employee Benefit Specialists (EBS), Inc.
PO Box 11657
Pleasanton, CA 94588
FAX: (925) 460-3929

2. Employer / Employee Information

check this box, if the address listed below is new

ANCHORAGE SCHOOL DISTRICT
Employer Name

Employee Name

Social Security Number

Employee Street Address

City

State

Zip Code

3. MEDICAL / DEPENDENT CARE EXPENSES

Name of Family Member	Relationship To Employee	Date of Service	Description of Expenses	Amount Requested
<input type="checkbox"/> Enter the total amount requested for reimbursement on this line and attach receipts:				

4. Employee Authorization

I certify that I (and/or my eligible dependents) have incurred expenses for which reimbursement is sought under the Employer's Flexible Spending Account Plan and that these expenses have been incurred during the Plan Year. Furthermore, I declare that I am requesting payment only for expenses that have not and will not be paid under any other benefit plan or program; and that I am solely responsible for the accuracy and veracity of all information relating to this claim. I authorize the Employer to reimburse the amount requested from my Flexible Spending Account.

Employee Signature: _____ **Date:** _____



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How to File a Claim

- ◆ Fill out the claim form completely. Please print clearly, or type, all requested information on the claim form.
- ◆ Be sure to include your Employer's name on the form.
- ◆ Be sure to note if there has been an address change. There is a checkbox on the claim form to indicate that the address listed is new.
- ◆ Be sure your calculations of the amount to be reimbursed are correct, and that they match the receipts or the Explanation of Benefits from the insurance company.
- ◆ Attach receipts for all eligible expenses.
- ◆ **Receipts MUST include the following information:**
 - ❖ name of the patient (you, your spouse or dependent);
 - ❖ the date the service was provided;
 - ❖ the name of the service provider;
 - ❖ a description of the service;
 - ❖ the amount/cost of the item or service provided
- ◆ **TOP 2 REASONS THAT CLAIMS ARE DENIED;**
 - ❖ Cancelled checks should not be used as proof of payment (not allowed by IRS) as the check does not provide information required for proof of service as noted above.
 - ❖ Statement from provider listing only payments made, do not provide all the information needed as described above (dates / description of service must be included per the IRS)
- ◆ Be sure all expenses were incurred during the Plan Year (or during the time you participated) before submitting.
- ◆ Be sure the expenses were not previously submitted.
- ◆ Make sure that all of the information provided on the claim form (particularly your name, address, and the name of your employer) is clearly legible. Claim forms that cannot be read are filed away until they are identified.
- ◆ Retain a copy of all claims forms and receipts, submitted to EBS, for your personal files. You will be charged a fee for EBS copying submitted information.
- ◆ If your claim cannot be processed, you will be notified in writing, explaining the reason and requesting the necessary information needed to process your claim.

EBS Account Balance and Claims Status

Information is available 24 hours a day, 7 days a week, by calling our automated systems at 800-EBS-FLEX (800-327-3539). If you prefer to check your balance, you can logon to the "member center" at www.ebsbenefits.com. If you need Customer Service assistance, they are available from Monday thru Friday, 9am to 5pm, Pacific Standard Time at 800-229-7683 or you can e-mail them at custserv@ebsbenefits.com.