



**HEALTH CARE /DEPENDENT CARE  
FLEXIBLE SPENDING ACCOUNT  
REIMBURSEMENT REQUEST FORM**

A. EMPLOYEE INFORMATION					
Name		Social Security Number (last 4 digits)		Employer Name	
Address		City		State	Zip
B. HEALTH CARE SPENDING ACCOUNT					
Dates of Service	Provider of Service	Person for Whom Service Provided	Relationship to You	Amount	
				\$	
<b>TOTAL AMOUNT REQUESTED</b>				\$	
C. DEPENDENT CARE SPENDING ACCOUNT					
Dates of Service	Provider of Service	Caregiver's SSN or ID#	Dependent's Full Name	Dependent's Date of Birth	Amount
					\$
<b>Provider Signature:</b>					\$
<b>Provider Address:</b>					<b>TOTAL AMOUNT REQUESTED</b>
D. CERTIFICATION					
<p>I certify that the following is true:</p> <ol style="list-style-type: none"> <li>1. <b>The expenses listed above were incurred by me and/or my eligible dependents and qualify for reimbursement within the current plan year. (See reverse side for a description of eligible expenses.)</b></li> <li>2. The expenses listed above are not eligible for reimbursement by any insurance plan.</li> <li>3. I have not and will not deduct the above listed expenses on my Federal Income Tax returns.</li> <li>4. The appropriate bills, receipts, Explanation of Benefit Statements or documentation for day care expenses are attached. <b>Please keep copies of supporting documentation for your records. Documents will not be returned.</b></li> <li>5. For Over-the-Counter medications to be eligible expenses under the plan, they must be for the diagnosis, prevention or treatment of a specific medical condition and not just for the overall good health of the participant. <u>A physician prescription or statement of medical necessity is required.</u></li> <li>6. If using the claim form as a daycare receipt, please have your daycare provider sign the claim form, authorizing the total requested charges (Section C-Provider Signature) and please provide your daycare providers address including street address, city, state and zip.</li> </ol> <p><b>**NOTE: If a portion of your medical expense(s) are covered by insurance, please send an Explanation of Benefits (EOB) for verification.</b></p>					
Employee Signature				Date	

Please return this form to:  
**TRUSTMARK**  
 Attn: Flex HB  
 P. O. Box 25946  
 Overland Park, KS 66225  
 Phone: 800-990-9058 ext 42086  
 Fax: 866-514-8287  
 Email address: [kcflexHB@trustmarkbenefits.com](mailto:kcflexHB@trustmarkbenefits.com)

## SPENDING ACCOUNT CLAIM FILING INSTRUCTIONS

1. Please complete the claim form in full and attach copies of all receipts, invoices, or Explanation of Benefit (EOB) statements. Documentation must clearly indicate:
  - Date services incurred or supplies purchased
  - Name and address of the provider of services or supplies
  - Name of the person receiving the service or supply
  - Type of expense
  - Amount of expense
  - Total amount paid by any insurance company
2. If any insurance company did not or will not reimburse you for ANY portion of an expense that you are submitting, please mark across the top of the invoice or receipt "NOT PAID BY INSURANCE" and initial it. If it is an expense which is part of your deductible, a copy of the EOB which indicates that, must be attached.
3. **DO NOT SEND CANCELED CHECKS OR STATEMENTS THAT ONLY INDICATE BALANCE DUE. THESE DO NOT SUPPLY THE REQUIRED INFORMATION.**
4. Claims submitted without the necessary information will be returned to the claimant and may cause a significant delay in processing reimbursement checks.
5. For daycare claims, you will need to submit a receipt from the daycare provider or individual providing daycare services to your eligible dependent(s), which reflects you have paid for the care. Include dates of service, Social Security of individual caregiver or Tax ID number of the daycare provider. This must be included on every claim. *NOTE: Charges for Kindergarten or private school programs that are strictly educational in nature are not covered. If your child is age 5-12 and in school, you are eligible to submit reimbursement for expenses for the following services: **before and after school care** & summer **daycare** & **summer camp** (excludes overnight camps).*
6. Keep copies of supporting documentation for your records. We will not return what has been submitted

### ELIGIBLE EXPENSES

Expenses, which can be legally reimbursed through the Health Care Spending Account, are those expenses allowed by the IRS as tax deductible medical expenses and are not reimbursed or paid for by a health care plan. These expenses must be incurred during the plan year. Such expenses include, but are not limited to the following:

#### MEDICAL EXPENSES

Abdominal Supports, if prescribed	Immunizations
Abortion Services	Midwife Expenses
Acupuncture	Obstetrician fees
Ambulance Hire	Orthopedic Shoes
Anesthesia	Osteopath
Artificial Limbs/Prosthesis	Oxygen
Alcoholism	Physical Therapy
Back Supports	Podiatrist
Birth Control Pills-prescribed by Doctor	Prescription Drugs
Braces	Psychiatric Care
Braille Books/Magazines	Psychologist
Chiropractic Services	Sex Therapy
Co-Payments& Deductibles for Insurance	Smoking Cessation Programs-if prescribed by Physician
Crutches/Wheelchair	Special Foods (related to medical condition)
Diabetic Supplies	Sterilization Fees
Diathermy	Transplants
Doctors Office Visits	Vasectomy
Fertilization Services	Well Baby Care
Gynecological Exams	X-Rays

#### DENTAL EXPENSES

Bridges  
Co-Payments & Deductibles - Insurance  
Crowns  
Denture  
Fillings  
Orthodontics (expenses incurred/current plan year)  
Dental implants

#### HEARING EXPENSES

Exams  
Hearing Devices, Aids and Batteries  
Special Communication Equipment for the Deaf

#### VISION CARE

Contact Lenses, Frames, Lenses  
Contact Lens Solution & Heating Units  
Laser Eye Surgery  
Oculist, Optician & Optometrist Services  
Radial Keratotomy Surgery

### INELIGIBLE EXPENSES

Expenses not eligible for reimbursement through the Health Care/ Dependent care Spending Account include, but are not limited to, the following:

Anti-Baldness Drugs	Electrolysis or Hair Removal	Maternity Clothes, Diaper Service
Bottled Water	Funeral and Burial Expenses	Nursing for Newborns
Cosmetics, Toiletries, Toothpaste, etc.	Health Club Dues (unless prescribed by Dr.)	Uniforms
Cosmetic Surgery	Household and Domestic Help	Vitamins (over the counter)
Custodial Care in an Institution	Illegal Operations and Treatments	Tuition for Kindergarten
Dental Procedures to Whiten Teeth	Insurance Premiums	Tuition for Private school
	Marriage Counseling	