FSA/HRA Claim Form

Company Name: _____

Please mail claims to:

The Walsh Group
Attn: FSA Administration
3638 Seneca Street
West Seneca, NY 14224

Phone: (716) 675-2100 Ext 19
Fax: (716) 675-4956

- ► Complete sections A and B. ***Form must be signed.***
- ► If expense is covered by insurance, submit to appropriate carrier
- ► Attach explanation of benefit (EOB) from the insurance carrier or co-pay receipts
- ► If you are submitting an itemized bill, indicate why this bill has not been paid by your insurance plan
- ► Itemized bills should include the Provider name & address, Patient name, Itemized charges, Date of service, and Type of service.
- ► Cancelled checks, non-itemized receipts, and balance due bills are not acceptable proof of expenses
- ► ***Be sure that your company name appears at the top of this form***
- ► Mail completed form with appropriate documentation for Healthcare Reimbursement request, to the address at the top of this form

A – Employee Information

Name: _____ Social Security Number: _____

Address: _____ Phone: _____

City, State: _____ Zip: _____

E-mail Address: _____

If this is a new address, please check □

B – Healthcare Expenses: Please circle one: FSA HRA

Please indicate if you have the following types of coverage: Medical: □ Yes * □ No

Dental: □ Yes * □ No Vision: □ Yes * □ No

*** If yes, please be sure to provide an explanation of benefits (EOB) or co-payment receipt**

Patient name	Provider	Date(s) of Service	Amount
		Total Healthcare Reimbursement Request:	

***** The minimum check amount is $35, unless the amount uses your remaining balance.***

I certify that the expenses for which I am requesting reimbursement meet all of the following conditions:

1. They were incurred for services or supplies by my eligible dependents or me under the plan.
2. They were for services or supplies furnished on or after the effective date of my employee spending account.
3. I have not been reimbursed for these expenses in any other way.

I understand that reimbursement of these expenses should be requested and made only after I have collected all benefit payments available from all plan under which my eligible dependents and I are covered. I further certify that I have not deducted or will not deduct on my individual income tax return any of these expenses reimbursed through my Health Care Account. I understand that reimbursement will be made in accordance with the guidance set forth by the Internal Revenue Service and the provisions of the plan. I accept all responsibility for the proper treatment of benefits under this plan with respect to eligibility, income tax reporting, and liability.

Employee Signature (required): _____ Date: _____