

# Flexible Spending Account Benefits Card Expense Substantiation Form



NOTE: it is not necessary to complete and return this form unless you have received an email or letter from CBCA Flex.

## Employee Information

Employer Name		Your Email Address	
Your Name (Participant)		Home Address	Check if New Address <input type="checkbox"/>
SSN	Daytime Phone	City	State Zip

If your claim includes expenses incurred by a spouse or eligible dependents, please provide the following information:

Name	Relationship to Employee	Date of Birth	Social Security Number
_____	_____	_____	_____
_____	_____	_____	_____

## Reimbursement Request

Please indicate your qualifying expenses below. **Do not include expenses reimbursed by any other source.** Attach bills, receipts, Explanation of Benefits summaries (EOBs) or other claim documentation. Documentation must include dates of service, description, provider's name and the expense amount. Cancelled checks are NOT sufficient proof of your claim.

### Health Care Spending Account

Date Range of Service	Brief description of all attached receipts
From: _____	_____
To: _____	_____

Important: If participating in the limited-purpose HCSA claims submitted can only be for dental or vision expenses

Total Health Care Reimbursement Request

### Claim Certification

I certify that these expenses for which my debit card has been used for the Flexible Spending Account have been incurred by me, my spouse or my eligible dependent(s) and are not payable by any other benefit plan or program. I have not and will not itemize and deduct, nor claim credit for these expenses on my individual income tax returns.

Employee Signature \_\_\_\_\_

Date: \_\_\_\_\_

### Dependent Care Spending Account

Dates of Service	Provider's Name	Provider Tax ID or Social Sec #	Amount
_____	_____	_____	_____

Total Dependent Care Debit Card Expense

Dependent Care Provider's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

(For office use only)

Claim # \_\_\_\_\_

Denial \_\_\_\_\_

Administrator Initials \_\_\_\_\_

Please submit this form along with supporting documentation to:  
CBCA Flex, 3510 Irwin-Simpson Road, Suite, B Mason, OH 45040  
Phone (866)754-1722, Fax (866)754-1833

## Flexible Spending Account Benefits Card Substantiation Instructions

1. Complete all information under **Employee Information** (please print or type). **Please include your e-mail address if you want to receive an automatic e-mail notification whenever a claim is received and processed.**
2. Attach supporting documentation. Substantiation must accompany this request form for all claims received, only if you have received a letter or email from CBCA Flex. Be sure to keep copies of receipts, bills, etc. for your records. Originals will not be returned. **All substantiation must include the following items:**
  - Original **date** of service (not the date of payment)
  - **Type** of service performed (refer to list of eligible expenses to identify valid services)
  - Provider's **name** and address (and Tax ID / SSN for Dependent Care expenses)
  - **Amount** charged to you (do not include amounts reimbursed by another source)
3. For a **Healthcare Debit Card Expense**, complete all information in Health Care Spending account box under **Reimbursement Request** and attach proof of expense as described above. Sales tax is now includable in your total amount.
4. For a **Dependent Care Debit Card Expense**, complete all information in Dependent Care Spending account box under **Reimbursement Request** and attach proof of expense as described above unless provider's signature is included on the claim form.
5. Sign and date **Claim Certification** box.
6. **Fax or mail** this form and supporting documentation directly to:

CBCA Flex  
3510 Irwin Simpson Road Suite B  
Mason, OH 45040

Toll-Free: (866)754-1722  
Fax: (866)754-1833  
E-Mail: CBCAFlex@chard-snyder.com

7. **Important Reminders:**
  - All debit card claims are subject to adjudication. **Transfer between accounts is prohibited.**
  - Any items for which you have been reimbursed **cannot be claimed again** as a reimbursement request to your plan or as deductions or credits on your individual tax return at the end of the tax year.
  - If a **Dependent Care** claim is submitted for an amount that is larger than the amount credited to your account, then payments will be issued according to the amount available. Anything requested above the available amount will "backlog" and will be released as additional credits are made to your account. **IRS Guidelines prohibit the advancement of Flexible Spending Account dependent care funds.**
  - You may only be reimbursed for eligible expenses incurred **during** the current plan year.  
*Note: orthodontia expenses are reimbursed as designated by provider.*