



FLEXIBLE SPENDING ACCOUNT CLAIM FORM

CLAIMS SUBMISSION METHODS

If you have any questions call (866) 916-3475

FAX: (877) 213-8917
E-MAIL: NCFlexClaims@padmin.com
MAIL: P&A GROUP ATTN: NC FSA PLAN
17 Court Street Suite 500 Buffalo, NY 14202

Today's date: ____/____/____ # of pages: Plan year beginning for: 20____

New claim Re-submission of claim Response to claim denial

Employee Name:	
FSA ID Number or Social Security Number:	
Address:	
E-mail Address:	Home Phone: () Work Phone: ()

Medical Expense Reimbursement Account Total Amount Requested: _____

- Enclose insurance company statement or itemized bill from provider showing date of service, services rendered, provider of service, amount paid and, if applicable, amount covered by insurance
- Prescription claims MUST include the Rx number pharmacy receipt, not the cash register receipt
- Reimbursement for eligible mileage expenses is permitted

Dependent Care Reimbursement Account Total Amount Requested: _____

**Note: you MUST include provider Tax ID Number in the service provider column below*

Date of Service	Employee, Spouse or Dependent	Amount Requested	Type of Service (Rx, co-pay, dental expense, etc).	Service Provider/ Rx Number (Must be provided)
1.				
2.				
3.				
4.				
5.				

Requirements for claims submission:

- Please number each receipt according to the order of appearance on this form
- IRS guidelines do NOT consider cancelled checks as valid documentation
- Previous balances are NOT acceptable
- All reimbursements will be made payable to the employee

I certify that the above listed expenses have been incurred by me, my spouse or my dependent(s) and that they have not been reimbursed under any other health plan. I will not seek reimbursement for these expenses under any other health plan.

Employee's Signature _____

Date ____/____/____