



FSA REIMBURSEMENT CLAIM FORM

Please complete this form to request reimbursement of expenses incurred by you and/or eligible dependents. Itemized documentation of each expense must be provided. For questions, contact Customer Care at 1-844-786-3947.

PARTICIPANT INFORMATION (to be completed by participant)

Participant Name:	
Employer Name:	
Employee Number/ID:	
Email Address:	
Home Address:	

Please list each eligible expense below:

Under the **Benefit Type** column, select one of the following benefit codes for each expense.

- | | | | |
|-------------------------|---|--|----------------------|
| FSA – Health FSA | LPFSA - Limited Purpose Health FSA | DCA – Dependent Care Account | TRN – Transit |
| PKG – Parking | DVFSA – Dental/Vision Health FSA | PRA – Premium Reimbursement Arrangement | |

Under the **Service Code** column, select one of the following service codes.

- | | | | |
|------------------------------|---------------------|---------------------|---------------------------------|
| MT – Mass Transit | PK – Parking | MD – Medical | RX – Prescription Drugs |
| OT – Over-the-Counter | VS – Vision | DN – Dental | IP – Individual Premiums |

Paid with TASC Card	Benefit Type	Date of service	Service Code	Service Provider	Dollar Amount

For quick reimbursement, file online via your employee portal or Mobile App!

Submit your claim form with supporting documentation via FAX to 877-231-1287.

To the best of my knowledge and belief, my statements on this Request for Reimbursement are complete and true. I am requesting reimbursement only for eligible expenses incurred during the applicable Plan Year and for eligible Plan Participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I understand that the IRS regulates my FlexSystem account and that these guidelines are implemented as a means of ensuring compliance and approval for reimbursement. I further understand that it is my responsibility to comply with these guidelines and to avoid submitting duplicate or ineligible requests, as doing so may delay payment. I authorize my Flexible Spending Account balance to be reduced by the amount requested.

Signature of Plan Participant

Date

TASC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
 ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-608-316-2408.
 LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-533-5020 (TTY: 1-800-947-3529).

Please fax or mail completed forms to:

Total Administrative Services Corp (TASC) • PO Box 7511 • Madison, WI 53707-7511
 Phone: 844-786-3947 • Fax: 877-231-1287 • SW-5531-101016