

**CLAIM FORM FOR MEDICAL / DEPENDENT CARE EXPENSES**

**1. Instructions (incomplete claim forms will not be processed)**

- Complete the Employee / Employer Information requested under Section 2.
- Fully complete all fields in Section 3. **Claim forms with incomplete information will be rejected.** Please list each receipt and itemize each expense. Additional pages may be attached. Receipts with a description of service(s) rendered or an Explanation of Benefits from your insurance provider are required for reimbursement. Credit card receipts or cashed checks are not acceptable documentation.
- Under Section 4, read the Employee Authorization carefully and sign noting your agreement.
- **Keep complete copies of all receipts and forms submitted to EBS for audit purposes.** EBS is not responsible for providing copies to participants.
- Completed claim forms should be **faxed to 925.460.3929 (preferred)** or mailed to the following address:  
EBS, P.O. Box 11657, Pleasanton, CA 94588  
**Fax: 925.460.3929 (preferred)**

**2. Employer / Employee Information**

**New Address? Check the box if the address listed below is new**

Employer Name \_\_\_\_\_

Employee Name \_\_\_\_\_ SSN \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_ Daytime Phone \_\_\_\_\_

**3. List of Eligible Expenses (over-the-counter expenses must be accompanied by a prescription)**

Family Member	Relationship to Employee	Date of Service	Description of Expenses	Amount Requested
JANE	SPOUSE	1.1.11	PRESCRIPTION	\$15.00
<b>&gt; Enter the total amount requested for reimbursement and attach receipts before sending</b>				

**4. Employee Authorization**

I certify that I (and/or my eligible dependents) have incurred expenses for which reimbursement is sought under my FSA plan and that these expenses have been incurred during the plan year. Furthermore, I declare that I am requesting payment only for expenses that have not and will not be paid under any other benefit plan or program and that I am solely responsible for the accuracy of all information relating to this claim. I authorize the Employer to reimburse the amount requested from my FSA plan.

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

## CLAIM FORM FOR MEDICAL / DEPENDENT CARE EXPENSES ~ INSTRUCTIONS

- Fill out the claim form completely. Please print clearly all requested information on the claim form.
- Be sure to include your employer's name on the form.
- Be sure to note if there has been an address change. There is a circle to check on the claim form to indicate that the address listed is new.
- Be sure your calculations of the amount to be reimbursed are correct and that they match the receipts or the Explanation of Benefits from your provider.
- Attach all receipts to the claim form before sending to EBS. Receipts **MUST** include the following information:
  - Name of the patient (you, your spouse or dependent) unless expense is an OTC purchase;
  - The date the service was provided or the date the item was purchased;
  - The name of the service provider or the merchant;
  - Description of the service or item purchased;
  - A prescription from your health provider if it is an OTC purchase; and
  - The amount/cost of the item or service provided.
- All over-the-counter (OTC) expenses must be accompanied by proper documentation from your health provider. The receipt for OTC expenses must include a description of the product, the date of the purchase, the name of the service provider (drugstore, doctor, etc.) and the amount of the item. Effective January 1, 2011, all OTC expenses must be accompanied by a prescription from your provider to be eligible under your FSA plan.
- Be sure all expenses were incurred during the plan year or period of active plan participation before submitting your claim.
- Verify that your expenses were not previously submitted or paid through your Take Care debit card.
- Retain a copy of all claim forms and receipts submitted to EBS. EBS is not responsible for providing copies to you.
- If your claim is rejected, you will be notified in writing explaining the reason and requesting the necessary information needed to process your claim.

### **Top two reasons claims are denied**

- Cancelled checks and credit card receipts are provided as proof of an incurred expense / purchase and
- The statement from the provider lists only payments made (does not list a description of the services rendered or does not list the dates of the services / purchases).

**Per the IRS, receipts are required that show both a description of services / purchases and the date of the services / purchases.**

### **Obtaining your Account Balance and Claims Status**

Account balance information is available 24 hours a day, 7 days a week, by calling our automated systems at 800-EBS-FLEX (800.327.3539). If you prefer to check your balance on-line, you can logon to your account through the Member Center at [www.ebsbenefits.com](http://www.ebsbenefits.com).

### **EBS Customer Service**

If you need Customer Service assistance, representatives are available from 8AM to 5PM PST, Monday through Friday at 888.327.2770 or you can e-mail EBS Customer Service at [custserv@ebsbenefits.com](mailto:custserv@ebsbenefits.com). Please do not include any confidential information, such as your Social Security number, in your email for security reasons.

