

MEDICAL REIMBURSEMENT ACCOUNT CLAIM FORM

FLEXIBLE SPENDING ACCOUNT

EMPLOYER NAME: _____

Employee Name

Social Security Number

Street Address (Apt. No.)

City/State/Zip

SEND CLAIMS TO:

**NAA – FSA PROCESSING CENTER
P. O. BOX 1984
NASHVILLE, TN 37202**

PHONE: 615-256-3561 or 800-411-3650

_____ Check if Name Change _____ Check if Address Change

Please enter information for which claim is being made in appropriate sections.

EXPENSES TO BE REIMBURSED:

Name/Relationship	Date of Service	Provider Name	Amount Requested
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

TOTAL AMOUNT REQUESTED: \$ _____

EMPLOYEE CERTIFICATIONS:

_____ I am covered under an insurance plan (group or individual) or an employer-sponsored employee benefits plan. My explanation of benefits (EOB) forms are enclosed.

_____ I have no insurance coverage for the attached expense(s). I have attached itemized bills and paid receipts.

I hereby certify that my request for reimbursement applies to claims for legitimate expenses incurred on the dates noted. I will not request reimbursement for these expenses from any other plan, and I will not claim these expenses on my income tax return to the extent I am reimbursed from my Spending Account.

SIGNATURE: _____ DATE: _____

DEPENDENT CARE REIMBURSEMENT CLAIM FORM

EMPLOYER NAME: _____

Employee Name

Social Security Number

Street Address (Apt. No.)

City/State/Zip

SEND CLAIMS TO:

NAA – FSA PROCESSING CENTER
P. O. BOX 1984
NASHVILLE, TN 37202

PHONE: 615-256-3561 or 800-411-3650

_____ Check if Name Change _____ Check if Address Change

Please enter information for which claim is being made in appropriate sections.

EXPENSES TO BE REIMBURSED:

Dependent Name: _____

Dates of Service From	To	Provider Name, Tax ID No., Address	Amount Requested
_____ \ _____		_____	\$ _____
_____ \ _____		_____	\$ _____
_____ \ _____		_____	\$ _____
_____ \ _____		_____	\$ _____
_____ \ _____		_____	\$ _____
_____ \ _____		_____	\$ _____
_____ \ _____		_____	\$ _____
_____ \ _____		_____	\$ _____

TOTAL AMOUNT REQUESTED: \$ _____

IMPORTANT: YOU MUST PROVIDE A RECEIPT FROM THE PROVIDER OF SERVICE.

I hereby certify that my request for reimbursement applies to claims for legitimate expenses incurred on the dates noted. I will not request reimbursement for these expenses from any other plan, and I will not claim these expenses on my income tax return to the extent I am reimbursed from my Spending Account.

SIGNATURE: _____ DATE: _____