Claim Form for Medical/Dependent Care Expenses

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

- Please see full list of instructions on the following page.

2. Employer/Employee Information

☐ **Is this a new address? Check box if yes.**

Employer Name _____

Employee Name _____ **SSN** _____

Street Address _____

City / State / Zip Code _____ **Daytime Phone** _____

3. List of Eligible Expenses

For receipts/EOBs to substantiate Visa Card Transaction(s), please mark "yes" in the Visa Card field.

Family Member	Relationship to Employee	Date of Service	Description of Expenses	Visa Card (Yes/No)	Amount Requested
Jane Doe	Spouse	1/1/21	Prescription	No	$15.00
Enter the total amount requested for reimbursement and attach receipts before sending.					

4. Employee Authorization

I certify that I (and/or my eligible dependents) have incurred expenses for which reimbursement is sought under my FSA or /HRA 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

Completed claim forms should be faxed or mailed to the following address:
EBS – Reimbursement Accounts
P.O. Box 850101, Minneapolis, MN 55485-0101
Fax: 925.460.3929
You can also email your claim to claims@workterra.com.

Instructions

- 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 Workterra for audit purposes.** Workterra is not responsible for providing copies to participants.
- Be sure to include your employer's name on the form along with the last four of your social.
- 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.
- Attach all receipts to the claim form before sending to Workterra. 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;
    - The amount/cost of the item or service provided.
- 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 Visa card.
- 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:

1. Cancelled checks and credit card receipts are provided as proof of an incurred expense/ purchase
2. 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 must show both a description of services/purchases and the date of the services/purchases.