FSA Reimbursement Claim Form

Please review MBA's Claim Submission Guidelines and Tips (on the back of this form) to ensure you include the proper documentation for this claim. MBA will not be able to process your claim without the adequate documentation. Keep a copy of all original documentation.

Employee Information

EMPLOYER			
Employee Last Name	First Name	Social Security Number (SSN)	
Mailing Address	City, State and Zip	Is this a new address? ☐	
Employee Email Address		Phone	

Medical Reimbursement Information

Date of Service (MM/DD/YY)	Patient's Name	Relationship	Type of Service*	Provider Name	Amount Requested
*For Orthodontia Claims - ☐ CONTRACT ON FILE WITH MBA				**MRA Total**	

Dependent Care Reimbursement

Date of Service (MM/DD/YY)	Dependent's Name	Relationship	Type of Service	Provider Name	Amount Requested
				DCR Total	

Plan Name Definitions *(Please refer to your Enrollment Letter to verify which plan(s) apply - not all Employers offer all plans.)*

Medical Reimbursement	This plan is for your out of pocket medical expenses. Medical expenses are the costs for diagnosis, cure, mitigation, treatment or prevention of disease, and the costs for treatments affecting any part or function of the body. They include the costs of equipment, supplies, and diagnostic devices needed for these purposes. They also include dental and vision expenses. (IRS Publication 502 – www.irs.gov)
Dependent Care	This plan is for childcare that allows the parent or guardian to work. Reimbursements can only be made for those services already provided. The total of any reimbursed dependent care expenses cannot exceed you or your spouse's earned income for the year and/or does not exceed $5,000 ($2,500 if married and file a separate tax return).

I certify that the above information is correct and hereby authorize release of payment through my reimbursement account(s). I further certify that these expenses have not been and will not be reimbursed from this plan, any other health plan coverage, or any other plan. I alone am responsible for the sufficiency and accuracy of all information relating to this claim and that, unless an expense under the Plan, I may be liable for payment of all related taxes, including federal, state, or city income tax on amounts paid from the plan that relate to such expenses.

Employee Signature	Date

Please submit your claim form and appropriate supporting documents:

Fax: (208) 887.1313
Mail: MBA | Attn: Claims Processing
PO Box 370 | Meridian, ID 83680
Email: CLAIMS@mba-admin.com

CLAIM SUBMISSION GUIDELINES & TIPS

Required for ALL Claims:

All Medical Reimbursement or Dependent Care FSA claims submitted MUST include:

- ☑ Completed MBA Reimbursement Claim Form Signed by the Employee
- ☑ AND –the following required documentation:

Required for Medical Reimbursement Claims:

Medical, Dental or Vision Claims *WITH Insurance and/or Secondary Coverage*	**Medical, Dental or Vision Claims** *WITHOUT Insurance Coverage*

• Include an Explanation of Benefits (EOB) from the insurance carrier
• The EOB should indicate the out-of-pocket expense
	• Include an itemized bill or receipt from the provider that includes the following:
	  • Patient's Name
	  • Type of Service
	  • Provider's Name and Address
	  • Dollar Amount
	  • Date(s) of Service

Required for Pharmacy Claims:

Prescription Drug Claims *Filled at a Pharmacy or Mail Order*	**Over-the-Counter (OTC) Drug Claims**

• Include an itemized bill or receipt from the provider that includes the following:
  • Patient's Name
  • Patient Costs / Carrier Payment
  • Prescription Number *(Drug name not necessary)*
  • Pharmacy's Name and Address
  • Dollar Amount
  • Date(s) when Prescription was dispensed
	• Written Prescription by Physician prescribing the OTC drug
	• Cash Register Receipt
	  • Facility's Name and Address
	  • Dollar Amount with an indication of an FSA eligible expense and/or name of OTC drug
	  • Patient Costs
	  • Date(s) of Service

Required for Orthodontia Claims:

Orthodontics Services	

• First orthodontic submission, please provide the orthodontia contract that indicates:
  • Initial Fee Charged
  • Estimated Insurance Payment (*if applicable*)
  • Initial Start Date
  • Duration of Treatment
  • Proof of Payment on Down Payment
	• Each request for monthly payment reimbursement must include an itemized bill/statement or receipt that indicates:
	  • Orthodontist Name and Address
	  • Patient's Name
	  • Monthly Amount that was indicated on contract
	  • Future Dates of Service cannot be submitted

Certain therapy services or items may not be covered by your insurance. If these are eligible expenses as per the IRS regulations, a letter from your attending physician indicating medical necessity may be required.

Required for Dependent Care Claims:

Dependent Care Service	

• Third-party documentation indicating:
  • Name and Address of Provider/Facility
  • Provider/Facility's Social Security Number or Tax ID Number
  • Dependent's Name
  • Date(s) of Service
  • Dollar Amount
	• Future Dates of Service cannot be Submitted for Dependent Care Reimbursement