FSA Claim Form

Page of

You can also submit claims and upload receipts online by logging in to **member.cdphp.com**.

Check each applicable box:

☐ Dependent Care Reimbursement ☐ Health Reimbursement

Employer:

Subscriber Name: Subscriber ID #:

Address:

City: State: ZIP:

Phone: Email:

FSA EXPENSE CLAIM FORM

Does your receipt include all of the following? ☐ Provider's name ☐ Provider's address ☐ Description of service or product ☐ Requested amount ☐ Actual date(s) of service (Date of payment is not sufficient)

Patient or Dependent's Name	Relationship to Subscriber	Date of Birth	Date of Service	Description of Service or Product	Requested Amount

Attach appropriate receipt(s) and submit with this claim form to ensure proper processing.

Total FSA Expense **$**

Read Carefully: The undersigned participant in the Flexible Spending Benefits Plan (Plan) hereby certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under his or her employer's plan. In addition, the undersigned participant certifies that the medical expenses have not and will be not reimbursed under any other health plan coverage. The undersigned understands that he or she alone is fully responsible for the sufficiency, accuracy, and validity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper and eligible expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense. The undersigned agrees that reimbursement is being requested for the undersigned, his or her spouse, and/or his or her federal tax dependents.

There may be certain limitations on the types of health care expenses that are eligible for reimbursement under the Plan. If you have specific questions regarding the types of expenses that are covered under the Plan, please contact your employer's benefit department.

Subscriber's Signature Date

Submit claims and upload receipts online by logging in to member.cdphp.com, or mail or fax claim form and receipts to:
CDPHN • P.O. Box 6130 • Albany, NY 12206-0130 • **Fax:** (518) 641-3502

Funding account questions? Call (518) 641-3770 or toll free 1-877-793-3960

Access your account information 24/7 at member.cdphp.com

FSA Claim Form and Filing Instructions

Your claim is important to us. To ensure CDPHP® is able to process your reimbursement for health care or dependent care expenses, complete the attached FSA claim form. Please review the guidelines listed below to ensure all necessary information is included when filing your claim.

- This plan is governed by IRS guidelines. In order to satisfy IRS requirements, documentation is needed to process your claim. Include a receipt or explanation of benefits (EOB) for every expense. The receipt or documentation must contain:
  - ☐ **Date of service –** Date service(s) occurred or date item was purchased.
  - ☐ **Provider's name and address –** Who delivered the service, or if a purchase, where item was purchased.
  - ☐ **Description of service –** Description of the service or product that was paid for.
  - ☐ **Requested amount –** The amount paid for the services or product and/or portion not reimbursed through your other insurance carrier.
- Circle the dollar amount being claimed on each receipt. Do not use a highlighter.
- If you are covered by other insurance for the services provided, you should submit those charges to the insurance company first and then send the EOBs to us along with this claim form.
- If you have dental insurance, please send a copy of your EOB with your proof of payment.
- If you have medical coverage for eyeglasses and contacts, you should only pay with your FSA for the amount above your medical allowance. Your vision provider should submit a claim for medical coverage directly to the insurance company.
- Cancelled checks, credit card slips, or statements showing only balance due on your account are not allowable.
- Claims must be received by CDPHN within the timeframes specified in your Plan. Claims must be submitted after a service is provided, but before the end of the run-out period following the end of your Plan Year.
- The expenses being claimed cannot be reimbursed from any other source.
- Keep a copy of the claim form and supporting documents for your records.
- In the event you are asked to resubmit a claim due to insufficient information, you must submit a new claim form with the requested information.

Fax your claim form with receipts to CDPHN at (518) 641-3502, or mail them to CDPHN, P.O. Box 6130, Albany, NY 12206-0130.

You can also submit claims and upload receipts online, or check your account balance status any time, day or night, by logging in to **member.cdphp.com**.

Discrimination is Against the Law
Capital District Physicians' Health Plan, Inc. (CDPHP®) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Multi-language Interpreter Services
ATENCIÓN: Si habla otro idioma que no es el inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que figura en su tarjeta de identificación de miembro (TTY: 711).

注意：如果您使用的語言不是英語，您可以免費獲得語言援助服務。請致電您會員ID卡上的電話（聽力障礙電傳：711）。