FSA/DCA COVID-19 CLAIM FORM FOR PRIOR YEAR FUNDS
MAIL TO: 1145 Westmoreland El Paso, TX 79925
915-532-3778 ext. 1529 or 1-877-532-3778
FAX TO: 915-298-7863 ATTN: TPA Department

Use this claim form to receive reimbursement for qualified medical and dependent daycare expenses incurred from October 1, 2020 through the end of the designated COVID-19 pandemic period with an additional two-month grace period extension.

Employee Name (Last, First, Middle Initial)	Employee Social Security Number
Employer Name	Daytime Phone Number

NOTE: *To make an address change, please contact your employer's HR/Benefits department.*

Health Care Claims *(For you or your dependents)*

For additional information, please visit our website at www.preferredadmin.net

- **Covered by Insurance** — Expenses for services or items must be submitted to your insurance company before submitting for reimbursement under your flexible spending account. When you receive the Explanation of Benefits Statement (EOB) for Dental or Vision, include a copy with this completed claim form. If you have a copay, attach an itemized statement from your service provider.
- **Not Covered by Insurance** — For services or items, submit an itemized statement from the provider showing the provider's name and address, patient name, date the service was provided, a description of the service, and the amount charged along with this completed claim form. Balance forward statements, cancelled checks, credit card receipts or received-on-account statements are not acceptable. Orthodontia claims require an itemized statement/payment receipt, the orthodontist's receipt, the orthodontist's contract/payment agreement or monthly payment coupon.
- **Prescription and Over-the-Counter Drugs and Medicines** — require a print-out of prescriptions from your pharmacy or must be clearly identifiable on an itemized receipt. Quantities purchased must be reasonably able to be consumed during the current plan year. Items for maintaining general good health, cosmetic purposes and dietary supplements are not eligible.

DATE INCURRED	NAME OF SERVICE PROVIDER OR DESCRIPTION OF EXPENSE	NAME OF ELIGIBLE DEPENDENT OR "SELF"	SSN	DOB	RELATIONSHIP OR "SELF"	ELIGIBLE EXPENSE
					Total Eligible Health Care Expenses	$

Dependent Child or Adult Day Care Claims

For additional information, please visit our website at: www.preferredadmin.net

Complete this form and attach an itemized statement from your day care provider or have your provider complete the information below. IRS regulations allow payment of services for dependents under age 13 or otherwise satisfying the "Qualifying Person Test" as described in IRS Publication 503. Payment is only allowed for services that have already been provided, not for services to be provided in the future. You are required to report the provider's name, address and Tax Identification Number or Social Security Number on Form 2441 with your personal income tax return.

EXACT DATES OF SERVICE FROM	TO	DEPENDENT NAME	SSN	DOB	AMOUNT REQUESTED
				Total Eligible Health Care Expenses	$

Day Care Provider Information:

Name _____ Provider Signature _____

I certify that these eligible expenses have been incurred by me, my spouse or eligible dependent and medical expenses are not for cosmetic purposes but for the treatment of an illness, injury, trauma, or medical condition. I understand that "incurred" means the service has been provided that gave rise to the expense, regardless of when I am billed or charged for, or pay for the service. The expenses have not been reimbursed and I will not seek reimbursement elsewhere. I understand that any amounts reimbursed may not be claimed on my or my spouse's income tax returns. I have received and read the printed material regarding the reimbursement accounts and understand all of the provisions.

Employee Signature _____ Date _____

* * * *Make copies for yourself, since these documents will not be returned. If you FAX your claim, keep the original.* * * *