



**HEALTH/DEPENDENT CARE
FLEXIBLE SPENDING ACCOUNT CLAIM FORM**

MAIL TO: 1145 Westmoreland El Paso, TX 79925
PH# (915) 532-3778 ext. 1507 or 1-877-532-3778 **FAX**
TO : (915) 225-1174 **ATTN:** TPA Dept.
EMAIL: fsapreferredadmin@elpasohealth.com

Member Name (Last, First, Middle Initial)			Member Social Security Number			
Employer Name			Daytime Phone Number			
Health Care Claims (For you and your dependents) <i>NOTE: Each expense should be itemized below. To make an address change, please contact your employer's HR/ Benefits department. For additional information, please visit our website www.preferredadmin.net</i> 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. Services must be accompanied by an itemized receipt/or 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 prescription or print-out from your pharmacy and must be clearly identifiable on an itemized receipt. Items for maintaining general good health, cosmetic purposes and dietary supplements are not eligible. A letter of medical necessity is acceptable.						
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 <i>For additional information, please visit our website at: www.preferredadmin.net</i> 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 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 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***						