MONROE COUNTY
FSA/HRA CLAIM FORM

Please read these instructions before completing the claim form:

1. *Employee must complete Part I. (If applicable, complete Part II and/or Part III).*
2. *Instructions for Part II "Health Care Expenses":*
   Check which account box you would like this claim to be paid from.
   A. *Expenses covered by your spouse's or your health care plan(s) must be submitted to that/those plan(s) prior to submission to your flex medical reimbursement account. Attach a copy of the explanation of benefits statement or itemized bill showing health care plan(s) payment(s) in order to claim your patient responsibility amounts.*
   B. *For all other eligible health care expenses, attach an itemized receipt that clearly states the name and address of the provider, date of service, service rendered, name of person receiving the service and the amount charged*
3. *Instructions for Part III "Dependent Care Expenses": Attach a copy of a receipt that includes the Federal ID# or SS# of the provider, name and address of the provider, name of dependent receiving the service, amount paid, and date (or date range) the service was provided. Federal form W-10 for each dependent care provider must be on file in our office.*
4. *Read the Employee Statement, sign and date the form.*
5. *Mail (or fax) the completed form to the address (or fax number) provided on this form.*

Part I: Employee Information (Please Print)

Employer Name:		
Employee Name:	Employee Social Security Number:	
Address:		New Address? ☐ YES ☐ NO
Daytime Phone	Evening Phone	

Part II: Health Care Expenses

Select which account you would like your claim paid from (Either choose FSA or HRA account, ONE account per claim form):
An account must be selected or your claim form will be returned to you un-processed.

☐ Flexible Spending Account (FSA-Payroll Deducted) ☐ Health Reimbursement Account (HRA)

Covered Person	Date of Service	Provider	Amount Claimed	**Administrative Use Only**
		Medical Expenses Subtotal	**$**	

Part III: Dependent Care Expenses (Day Care Services)

Dependent Name	Date of Birth	Provider	Date(s) of Service MM/DD/YYYY		Amount Claimed	**Administrative Use Only**
			From:	**To:**		
			From:	**To:**		
			From:	**To:**		
			Dependent Care Expenses Subtotal		**$**	

Total Amount Claimed	**$**

Employee Statement:

I request payment from my Cafeteria/Flexible Benefits Account(s) for the expenses itemized on this claim form. I certify that I have not received reimbursement under this Plan or from any other source for these expenses and that I will not seek additional reimbursement for the amount(s) paid by this Plan. I further certify that I have met all requirements for eligible expenses under this Plan. I understand that expenses for which I have been reimbursed cannot be claimed on my personal income tax return.

Employee Signature: _____ Date: _____

Send completed claim form to:

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Fairport, NY 14450
www.heginc.com

(585) 241-9500, ext. 504
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