Claim Form

DO NOT USE YOUR CARD TO PAY FOR SERVICES OR PURCHASES FROM THE PREVIOUS PLAN YEAR. YOU MUST FILE A MANUAL CLAIM USING THIS FORM FOR REIMBURSEMENTS INCURRED IN THE PREVIOUS PLAN YEAR AND THAT HAVE NOT PREVIOUSLY BEEN REIMBURSED.

USAdmin Services, LLC (Febco Division)

Participant Information

Employer Name: _____

Employee Name: _____ **Email Address:** _____

Social Security Number: _____ **Birthday:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

To prevent delays in claim processing, please make sure all areas are completed and supporting documentation is included. Please be aware that CANCELLED CHECKS or CREDIT CARD receipts will not substantiate an expense being incurred, only that a payment was made. The IRS requires that Receipt Documentation reflect all of the following information before reimbursement is allowed: (1) Patient's name (2) Date of service (3) Provider information (4) Amount of expense, and (5) Description of the service/product purchased. Acceptable documentation will be a doctor's office receipt showing the above information, the prescription tag (no cash register receipts), itemized bill for glasses/contacts, etc. You may also send an EOB reflecting the necessary information. ALWAYS RETAIN A COPY OF ALL INFORMATION SENT TO FEBCO REQUESTING REIMBURSEMENT.

Claim Information

RECEIPT/EOB #1

Benefit Account: _____ Patient's Name: _____

Amount of Charge: $ _____ *Dates of Service: _____ to _____

Merchant/Physician Name: _____ *Deduct from Previous Plan Year: ☐

Description of Service: _____

RECEIPT/EOB #2

Benefit Account: _____ Patient's Name: _____

Amount of Charge: $ _____ *Dates of Service: _____ to _____

Merchant/Physician Name: _____ *Deduct from Previous Plan Year: ☐

Description of Service: _____

RECEIPT/EOB #3

Benefit Account: _____ Patient's Name: _____

Amount of Charge: $ _____ *Dates of Service: _____ to _____

Merchant/Physician Name: _____ *Deduct from Previous Plan Year: ☐

Description of Service: _____

RECEIPT/EOB #4

Benefit Account: _____ Patient's Name: _____

Amount of Charge: $ _____ *Dates of Service: _____ to _____

Merchant/Physician Name: _____ *Deduct from Previous Plan Year: ☐

Description of Service: _____

Employee Name: _____

RECEIPT/EOB #5

Benefit Account: _____ Patient's Name: _____

Amount of Charge: $ _____ *Dates of Service: _____ to _____

Merchant/Physician Name: _____*Deduct from Previous Plan Year: ☐

Description of Service: _____

RECEIPT/EOB #6

Benefit Account: _____ Patient's Name: _____

Amount of Charge: $ _____ *Dates of Service: _____ to _____

Merchant/Physician Name: _____*Deduct from Previous Plan Year: ☐

Description of Service: _____

RECEIPT/EOB #7

Benefit Account: _____ Patient's Name: _____

Amount of Charge: $ _____ *Dates of Service: _____ to _____

Merchant/Physician Name: _____*Deduct from Previous Plan Year: ☐

Description of Service: _____

RECEIPT/EOB #8

Benefit Account: _____ Patient's Name: _____

Amount of Charge: $ _____ *Dates of Service: _____ to _____

Merchant/Physician Name: _____*Deduct from Previous Plan Year: ☐

Description of Service: _____

IF ADDITIONAL RECEIPTS NEED TO BE SUBMITTED, PLEASE USE ANOTHER CLAIM FORM

Signature *(Incomplete forms will not be processed)*	**Total**	**$**

Your claim will be processed based on the date the claim is received. If you are receiving a reimbursement via direct deposit, please confirm with your financial institution that funds have been received and are available for your use. Febco cannot be responsible for overdraft fees and cannot guarantee delivery of checks received through the mail. Because Febco is charged a fee for canceling and reissuing a lost check, any bank fee must be passed along to the participant requesting reissuance. Should you not receive your reimbursement, please contact our office immediately at (855) 872-3646. If you wish to change your request for a check reimbursement to a direct deposit reimbursement, please complete the banking Direct Deposit Form and accompany it with this Claim Form.

CERTIFICATION

I certify the above information to be true to the best of my knowledge, that I am requesting reimbursement for eligible expenses incurred during the applicable plan year and that I am eligible to receive benefits. I also certify that these expenses have not been previously reimbursed by this or any plan and will not be claimed as an income tax deduction.

Employee Signature: _____ **Date:** _____/_____/_____

You can mail this form to:

P. O. Box 11045, Chattanooga, TN 37401

For faster service fax this form to: (423-634-0625)
or e-mail to flex@usadmin.com