FLEXIBLE SPENDING ACCOUNT
CLAIM FORM & FILING INSTRUCTIONS

On the reverse side of this page is a claim form. Please feel free to copy this from.

Mail / Fax / Email / Deliver requests for reimbursements to:
Mailing Address: PO Box 880, Freeport, IL 61032
Fax: (815) 599-7059
E-Mail: NIHPCustomerservice@fhn.org

After you fax a request and receipts, please do not follow-up with a hard copy in the mail. *(Please remember to keep a copy of the claim form and supporting documents for your records).*

When filing your claim, you must attach copies of the receipts. According to the Internal Revenue Code, the Flexible Spending Account may reimburse an expense if the participant provides:

- A written statement, receipt or bill from an independent third party stating the expense(s) has been incurred;
- The amount of such expense(s);
- A signed statement that the expense has not been reimbursed or is not reimbursable under any other health plan coverage or a Flexible Spending Account.

*Please note that it is **your** responsibility to provide support for this claim in the event of an audit by the IRS.

Procedures for submitting claims that will help to ensure prompt and efficient processing:

- Date of service,
- Description of services provided,
- Patient name,
- Provider name and address,
- Total amount of payment for which you are seeking reimbursement,
- An Explanation of Benefits (EOB) from an insurance company, if applicable, must also be submitted.
- Over the counter drugs and items must have a receipt that contains the date purchased, name and cost of item. If the receipt does not provide a name, then a box top or box side should be submitted that contains the name and cost of item that corresponds to the receipt.

YOU MUST SIGN AND DATE THE CLAIM FORM WHEN SUBMITTING FOR REIMBURSEMENT.

NORTHERN ILLINOIS HEALTH PLAN

FLEXIBLE SPENDING ACCOUNT – CLAIM FORM – STEPHENSON COUNTY

EMPLOYEE NAME: _____ EMPLOYEE SSN: _____

ADDRESS: _____ CITY: _____ ST: ____ ZIP: _____
THIS IS A CHANGE OF ADDRESS / NEW ADDRESS: ☐ YES ☐ NO

MEDICAL/DENTAL/VISION EXPENSES - ATTACH BILLS, RECEIPTS, OR EOB TO CLAIM FORM

Item	Patient Name	Date (s) of Service	Provider (Person or Business)	Reimbursement Required
1				
2				
3				
4				
5				

DEPENDENT (CHILD/ELDER CARE) EXPENSES – ATTACH BILLS OR RECEIPTS TO CLAIM FORM

Item	Dependent Name	Date (s) of Service	Provider (Person or Business)	Reimbursement Required
1				
2				
3				

*__Dependent Care Expenses__ – If the amount of the above expenses exceeds the balance in your account, ***do not*** resubmit for the unreimbursed portion on this claim. You will automatically be reimbursed as your account balance allows.

I hereby certify that:

- The information given on this reimbursement form is complete and accurate.
- I have not previously received reimbursement for these expenses from this Flex account or any other source.
- The total of reimbursed dependent care expenses does not exceed the lessor of my spouses or my earned income (W-2 Pay) for the year, if less that $5,000.
- All heath and dependent care expenses listed above comply with the requirements and guidelines listed in the Flexible Spending Reimbursement guidelines and meet the definition of a medical expense as defined in Code Section 213 and ruling and Treasury Regulations thereunder.

_____ _____

Employee Signature* Date*

*Note: Form must be signed and dated in order to process this claim. **MINIMUM CHECK AMOUNT $20.00**

****KEEP A COPY FOR YOUR FILES ****

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