

Internal Use:
Date: _____
Entered by: _____
Denial: _____
Total: _____ on _____

**FLEXIBLE SPENDING ACCOUNT CLAIM FORM**

Employer Name	SS# Last Four Digits
Employee Name	Best way to reach you: phone # or email address
Address	City · State · Zip Code <span style="float: right;">Please check box if address is new <input type="checkbox"/></span>

Please submit your claim with an Explanation of Benefits (EOB) from your insurance carrier or a receipt from the provider. All supporting documentation must include the name and address of the provider, patient's name, date, description and amount of the service. Canceled checks, credit card receipts or credit card statements alone are not considered valid substantiation.

Date of service or purchase date(s) From/To	Name of Service Provider *Multiple receipts for the same provider may be combined*	Descriptions of Services OTC – Over the Counter Rx – Prescriptions MD – Office visit or co-pay DN – Dental    VS – Vision	Person(s) For Whom Expense was Incurred	Total Amount For this Provider

**Total Health Care Expenses:**                    \$ \_\_\_\_\_

**Dependent Care Spending Account**

Service Date(s) Range From/To	Name of Dependent Care Provider	SS# or Tax ID# of Provider	Dependent's Name	Total Amount For this Provider

**Signature of Provider** \_\_\_\_\_ **Date** \_\_\_\_\_  
Certifies the above dependent care services have been provided. Required only receipt is not provided.

**Total Dependent Care Expenses:**                    \$ \_\_\_\_\_

**READ CAREFULLY:** The above is a true and accurate statement of all expenses incurred by my eligible dependents or me on the date(s) indicated, and were incurred while I was covered under the Flexible Spending Account(s). Supporting documentation from my service provider(s) for all expenses are attached to this claim form. I understand that I cannot claim any reimbursed expenses on my income tax return, and that I may be liable for payment of all related taxes including Federal, State, or City income tax and any associated penalties on the amounts paid for any expense improperly claimed under the provisions of the Flexible Spending Account(s).

Employee Signature Date

For your convenience, claims may be submitted four ways:  
**Email:** [benefitsadmin@capitalbauer.com](mailto:benefitsadmin@capitalbauer.com)      **Fax:** (518) 533-6852  
**Mail:** Capital Bauer • Attn: Benefits Admin Dept • PO Box 15094 • Albany, NY 12212-5094  
**Online:** [www.hrbenefitsdirect.com/capitalbauer](http://www.hrbenefitsdirect.com/capitalbauer)