Flexible Spending Account (FSA) Claim Form

NATIONAL BENEFIT SERVICES, LLC
Customer Care • Knowledge and Expertise • Organizational Excellence

Personal Information

Employee Name

Company Name: Southern Utah University

Home Address

Change? ☐ Yes ☒ No

Social Security Number: ___ - __ - ____

Phone Number: ___ - ___ - ____

For Quick Claim Processing:

- ► Fully Complete & Sign this Claim Form
- ► Attach a copy of supporting receipts, vouchers, bills, etc.
- ► All receipts must detail each of the items summarized below
- ► Please print in dark blue or blak ink when using this form
- ► Minimum Total Reimbursement $25

For Account Balance: Go To
www.NBSbenefits.com
Or Call
(801) 838-7324 or (888) 353-9125

Please allow 2 business days for claims to be processed

Day Care Expenses

	Date of Service Mo Day Yr	Service Provider Tax ID # or SS#	Child's Name	Age	Amount
1	__ - __ - __				____.__
2	__ - __ - __				____.__
3	__ - __ - __				____.__
	Total FSA Day Care Expenses				____.__

Health Care Expenses (Please list one expense per line)

****Notice****

Effective Jan. 1 2011 all over-the-counter (OTC) medication claims must be accompanied by a prescription to be eligible under new federal regulation

	Date of Service Mo Day Yr	Office Visit	RX	Dental	Vision	Non-Drug OTC	Ortho-dontia	Other Services: Please Specify	Person Receiving Service	Amount
1	__ - __ - __	○	○	○	○	○	○			____.__
2	__ - __ - __	○	○	○	○	○	○			____.__
3	__ - __ - __	○	○	○	○	○	○			____.__
4	__ - __ - __	○	○	○	○	○	○			____.__
5	__ - __ - __	○	○	○	○	○	○			____.__
6	__ - __ - __	○	○	○	○	○	○			____.__
7	__ - __ - __	○	○	○	○	○	○			____.__
8	__ - __ - __	○	○	○	○	○	○			____.__
9	__ - __ - __	○	○	○	○	○	○			____.__
10	__ - __ - __	○	○	○	○	○	○			____.__
									Total FSA Health Expenses	____.__

Employee Signature

I, the undersigned, attest that to the best of my knowledge these statements are complete and true. I authorize the release of any medical information to my spouse. I certify these expenses are for valid services provided on the dates indicated and will not be reimbursed or claimed under any other Plan, or claimed as a tax deduction.

Employee Signature
X

Date

NBS - 402(10/10)

Please fax or mail your claim form and receipts to the following:

Mail: National Benefit Services, LLC P.O. Box 6980, West Jordan, UT 84084
FAX: Salt Lake City Area Fax: (801) 355-0928 Toll Free Fax: (800) 478-1528
Email: claims@NBSbenefits.com (PDF, TIFF or JPEG files only)