



**Fax completed form to:**  
978.552.0172



**Mail completed form to:**  
AccrueHealth  
P.O. Box 100237  
Columbia, SC 29202



**Questions about this form?**  
1-844-643-3099  
M-F, 8:00 a.m. to 8:00 p.m. ET

## Member Information

Employee's Name

ID Number or SSN

Employer Name

## Health Claim Information

Patient's Name	Deductible	Coinsurance	Copayment	Other Expenses	Total Expenses
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$

**Recurring reimbursement:** Recurring reimbursement can be set up for orthodontia and global maternity expenses. Check this box and include a copy of your orthodontia contract or global maternity contract to receive monthly reimbursements.

## Dependent Care Claim Information

Dependent's Name	Date of Birth	Amount Requested	Dependent Care Provider Name	Provider Tax ID or SSN	Dates of Service
		\$			_____ to _____
		\$			_____ to _____
		\$			_____ to _____
		\$			_____ to _____

**Provider Certification:** Provider's signature certifies that services were rendered for the expenses listed above.

\_\_\_\_\_  
PROVIDER'S SIGNATURE

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
DATE

## EMPLOYEE CERTIFICATION

HRA Reimbursement – I authorize My Health Reimbursement Arrangement (HRA) to be reduced by the amount of expenses listed above. The expenses incurred by myself or my eligible dependents are not reimbursable from any other source. I understand that any expenses reimbursed cannot be claimed as credits or deductions on my income tax return. I further certify that I have read and understand the information outlined on the back of this form. The information on this form is true and correct to the best of my knowledge.

Health Care FSA and Dependent Care FSA – I authorize my Flexible Spending Account (FSA) to be reduced by the amount of expenses listed above. The expenses incurred by myself or my eligible dependents are not reimbursable from any other source. I understand that these expenses cannot be claimed as credits or deductions on my income tax return. I further certify that I have read and understand the information outlined on this form. The information on this form is true and correct to the best of my knowledge.

\_\_\_\_\_  
EMPLOYEE SIGNATURE

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
DATE



## Filing Information

### **Reimbursement for Health Care Expenses**

1. To be reimbursed with funds from your FSA or HRA, you must file an AccrueHealth Claim Form or submit a claim at [member.accrue-health.com](http://member.accrue-health.com). Attach an Explanation of Benefits (EOB) to the claim form. An EOB is mailed to you after a medical, dental or prescription drug claim has been processed.

In some cases, you may use an itemized bill or a cash receipt\* from a service provider instead of an EOB. For example, if you purchase a hearing aid (not covered by the medical plans) you may attach the receipt from your hearing aid dealer to the FSA Claim Form.

\*An itemized bill or cash receipt must include the following:

- a. Name and address of the provider
- b. Detailed statement of services rendered, with dates of services

For prescribed over-the-counter medicines that are reimbursable from your medical FSA, you must attach the prescription and the receipt which should include the date, name of the retailer, and a list of products purchased.

2. Please group all documents in order of the individual's name, and then by date of service.

Mail the completed claim form with attachments (EOBs and/or itemized bills) to the address listed on this form or submit for reimbursement at [member.accrue-health.com](http://member.accrue-health.com).

3. Keep copies of all claims submitted. Documentation mailed with this claim form will not be returned.

4. You must submit all FSA/HRA claims by the last day of the specified run-off period of the following year for expenses incurred during the plan year. Check with your company's Human Resources department for the exact date your run-off period ends.

### **Reimbursement for Dependent Care Expenses**

1. To be reimbursed with funds from your Dependent Care FSA, you must file an AccrueHealth Claim Form or submit a claim at [member.accrue-health.com](http://member.accrue-health.com). Attach a copy of your itemized bill from the provider with the following information:

- a. Name and address of the provider
- b. Social Security number or federal tax identification number of the provider
- c. Detailed statement of services rendered, with dates of services

3. Keep copies of all claims submitted. Documentation mailed with this claim form will not be returned.

4. You must submit all Dependent Care FSA claims by the last day of the specified run-off period of the following year for expenses incurred during the plan year. Check with your company's Human Resources department for the exact date your run-off period ends. Any money remaining in your account after the end of the plan year will be forfeited under Internal Revenue Service (IRS) guidelines.

Expenses to provide care for your eligible dependents may qualify for reimbursement. Eligible dependents include children under age 13, a disabled child, a disabled spouse, or a disabled parent for whom you are entitled to a personal tax exemption as a dependent.

To be eligible, you must be working while your dependents receive care. Also, if you are married, your spouse must be:

- A wage earner, or
- a full-time student for at least five months during the year, or
- Disabled and unable to provide for his or her own care.

Expenses eligible for reimbursement are those incurred to enable you to be gainfully employed, and include covered charges by:

- Licensed nursery schools and day care centers.
- Individuals (other than your dependents under age 19) who provide care for your children in or outside your home, or for your disabled spouse or dependent parent in your home.
- Housekeepers, maids or cooks in your home, to include their food and lodging in your home, as long as their services are performed for the benefit of your eligible dependent(s).

Under IRS regulations, the reimbursement when aggregated with all other dependent care reimbursement during the same year may not exceed the lesser of the following limits:

- \$5,000
- \$2,500 if you are married and your spouse files a separate tax return
- If you are single, your taxable compensation
- If married, the lesser of your earned income or your spouse's earned income for the year

IRS regulations limit the amount of reimbursement expenses for dependent care to the lower of the annual earned income of you or your spouse. If your spouse is disabled or a full-time student, this limitation assumes that your spouse earns \$200 per month (one dependent) or \$400 per month (two or more dependents). Under IRS regulations, qualified individuals can receive a tax credit for some dependent care costs. You may claim this credit on your personal tax return. You cannot claim the tax credit for any dependent care costs reimbursed from the FSA, since FSA funds are pre-tax withholdings.