**FAX: 585-389-7003**

Submit or view claims **ONLINE: https://benefits.paychex.com**

**Paychex Employee Services: 877-244-1771, automated system available 24/7, representatives available Monday - Friday, 8:00 a.m. - 8:00 p.m. ET**

FOR OFFICE USE ONLY

Docket # _____

PAYCHEX®

# Flexible Spending Account (FSA) Reimbursement Claim
# Unreimbursed Medical Expenses

**EMPLOYEE INFORMATION** (print)

Employee Name_____ Company Name _____

Social Security Number (last 4 digits)_____ Employee Telephone Number (_____)_____-_____

Email Address _____

## ** PLEASE DO NOT USE THIS FORM TO SUBMIT DEBIT CARD SUBSTANTIATION **

All claim reimbursements will be processed within two business days upon receipt of the completed claim form and all supporting documentation.

**INSTRUCTIONS CHECKLIST:**

- Enclose copies of all itemized bills, receipts, or Explanation of Benefits (EOB) from your provider or a copy of your orthodontia services contract, if applicable. ***We recommend using the FSA Orthodontia Claim Form (FSA045) to submit for Orthodontia services.*** Use blue or black ink only to identify FSA items on receipts. Do not use highlighter. **Copies of personal checks, cancelled checks, or credit card receipts are not valid for verification of service.**
- Verify that bills and receipts contain:
  - date of service
  - description of service
  - cost of service
  - provider's name
  - provider's address

**** Over the Counter medications will require a prescription from your doctor ****

- If you are currently funding a Health Savings Account (HSA) in addition to your FSA, your FSA is a limited purpose FSA and may only be used to pay for vision, dental, and preventative medical expenses.
- **Sign your claim form** and fax it to the number noted above. Retain a copy for your records.
- If you prefer, mail your claim to: Paychex, Inc., FSA Claims, PO Box 3000, Henrietta, NY 14467-3000.

| Name of Service Recipient | Relationship to Employee | Service Date(s) | Service Description | Service Provider | Amount |
|---|---|---|---|---|---|
| **SAMPLE**<br>John Doe | ☐ Self<br>☐ Spouse<br>❒ Dependent | 07/07/07 | ❒ Medical<br>☐ Dental<br>☐ Vision<br>☐ Pharmacy | Dr. Jones | $521.43 |
| | ☐ Self<br>☐ Spouse<br>☐ Dependent | | ☐ Medical<br>☐ Dental<br>☐ Vision<br>☐ Pharmacy | | $ |
| | ☐ Self<br>☐ Spouse<br>☐ Dependent | | ☐ Medical<br>☐ Dental<br>☐ Vision<br>☐ Pharmacy | | $ |
| | ☐ Self<br>☐ Spouse<br>☐ Dependent | | ☐ Medical<br>☐ Dental<br>☐ Vision<br>☐ Pharmacy | | $ |
| | ☐ Self<br>☐ Spouse<br>☐ Dependent | | ☐ Medical<br>☐ Dental<br>☐ Vision<br>☐ Pharmacy | | $ |
| | | | | **TOTAL** | $ |

If you have more claims, please complete additional Reimbursement Claim forms.

**CLAIM INFORMATION**

I certify that the information here is true and correct; that the expenses incurred were for myself, my spouse as defined by federal law, or my eligible dependents; and that these expenses are not reimbursable under any other health plan coverage.

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