National Fuel

P&A Group

Flexible Spending Account Claim Form

Today's Date: _____/_____/_____
# of pages: _____

❑ New Claim ❑ Resubmission of claim ❑ Please check if new address

This claim is for the plan year beginning in the year 200_

Employer Name/Division Name:	Employee Name:	
Employee Address:		
Social Security Number: XXX-XX-	E-mail Address:	Home Phone: Work Phone:

❑ **Medical Care Reimbursement Account** **Total Amount Requested** _____

- Enclose insurance company statement, if applicable, and itemized bill for the dental/medical claim(s)/co-payments you are submitting.
- Prescription claims **MUST** include the R_X number pharmacy receipt, not cash register receipt.
- Eligible over-the-counter items must be submitted with the cash register receipt that clearly substantiates the expense (i.e. cash register receipt with the name of the over-the-counter item electronically printed on it and not hand written.)

❑ **Dependent Care Reimbursement Account** **Total Amount Requested**_____

Dependant Care claims – (for child under the age of 13): Include provider name, provider tax identification number, child's name, dates of service and amount charged.

❑ **Individual Premium Reimbursement Account** **Total Amount Requested**_____

Please attach proof that employee owns policy.

❑ **Adoption Assistance Account** **Total Amount Requested**_____

❑ **Parking Reimbursement Account** **Total Amount Requested**_____

Date of Service	**E**mployee, **S**pouse or **D**ependent	Amount Requested	Type of Service (R_X copay, dental, etc.)	Service Provider/ R_X # (**MUST** be provided)
1.				
2.				
3.				
4.				
5.				

- Only **ORIGINAL DOCUMENTION** will be accepted (please keep a copy for your records).
- Enclose insurance company statement, if applicable, and itemized bill for the dental/medical claim(s)/co-payments you are submitting.
- Please number each items according to its order of appearance on this form.
- Prescription claims must include the RX number pharmacy receipt not cash register receipt.
- CANCELLED CHECKS, credit card and cash register receipts are generally not considered valid documentation and will not be accepted for reimbursement in lieu of original supporting documentation. (Cash register receipts are acceptable for eligible over-the-counter items only.)
- Previous balances are NOT acceptable.
- Complete all information on claim form including signature and date.
- All reimbursement will be made payable to the employee.
- Dependant Care claims: Include provider name, provider tax identification number, child's name, dates of service and amount charged.
- Premium Reimbursement claims: attach proof that employee owns policy.
- **FAXES/COPIES WILL NOT BE ACCEPTED**

I certify that my statements in this Reimbursement Voucher are complete and true. I am claiming reimbursement only for the eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed on this or any other benefit plan, and WILL NOT BE CLAIMED AS AN INCOME TAX DEDUCTION, and that I will not seek reimbursement of the expenses under any other health plan. I authorize my Flexible Spending Account to be reduced by the amount requested.

EMPLOYEE'S SIGNATURE_____DATE_____

Mail to: Flex Department, P& A Group 17 Court Street, Suite 500, Buffalo, NY 14202-3204
Visit our website to access account information at www.padmin.com or call
1-800-688-2611 / 716-852-2611

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