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FSA – MEDICAL CLAIMS FORM

Instructions: Reimbursement are made on approximately the 1st and 16th of every month for claims submitted in the previous 15 days. Please send this completed form with proper documentation to **RPG Consultants – FSA Department at the address above**. Please keep a copy of all correspondence for your records. Copies of this form are available at www.rpgny.com.

Documentation: You must complete this form (send original) and attach documentation (copies only – keep originals) to ensure timely reimbursement. This form must be signed and dated and you must include:

- Proof of expense (expense type, provider, dates of service, name of patient)
- Proof of payment (cancelled check, credit card slip, month-end credit card statement, “paid in cash” statement indicated below for items under \$100.00).
Credit Card: Attach slip or month-end statement. *Check:* Indicate check # and include cancelled check front and back. *Cash:* No receipt needed if under \$100 otherwise register receipt.
- Insurance company Explanation of Benefits (EOB), if applicable

Eligible Expenses: Please refer to our website at www.rpgny.com for more information. You may also e-mail us at fsa@rpgny.com with any questions. Your contact information below will be used if there are questions about your claim.

Employee Information:

Name: _____ Company Name: _____
 SS: _____ Date of Birth: _____ Check one: Married Single
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____ E-mail: _____

Date	Patient	Relationship	Provider	Description	Cash/Credit Card/Check	Amount

(Additional expenses should be placed on separate forms. Each form treated as individual claim)

Total Medical Expenses: \$ _____

I request reimbursement for the attached expenses under the Section 125 Cafeteria Plan established by my company. I certify that I, or my eligible dependents, have incurred these expenses. Furthermore, I declare that these expenses have not been reimbursed from any other source nor do I expect them to be. I certify that these expenses are for medical expenses as defined by Section 213 of the Internal Revenue Code.

Signature: _____ Date: _____