How to File Claims

IRS guidelines require specific documentation to substantiate each claim submission. The following chart provides an easy description of how to file claims and the type of documentation that is acceptable. Also included is a description of documentation that is not acceptable.

If Covered By Insurance	It is recommended that you submit to your insurance carrier first and obtain the insurance explanation of benefits (EOB) as follows: 1. Have the provider submit claim to insurance payer first. 2. Insurance payer will send you an **Explanation of Benefits (EOB)** showing the amount you owe. 3. Complete FSA claim form and include EOB to claim the amount you owe after insurance has paid. ★ *Hint: You can register at your insurance carrier's website to view your account and obtain the EOB.*
Prescriptions	Complete FSA claim form and include: • Pharmacy script or mail order statement showing patient name, name of drug/Rx item, date filled, dollar amount; **or**, • Itemized printout of prescription from pharmacy. ★ *Hint: You may be able to register at your pharmacy website to view your account and obtain an itemized list of prescriptions.*
Over-the-Counter Drugs/Medicines FSARx☑	Complete FSA claim form and include: 1. Cash register receipt showing merchant name, date, product description, dollar amount; **and**, 2. Written prescription from the patient's attending physician. ➔ ***Note:*** *Examples are antacids & digestive aids, allergy & sinus, antibiotic products, anti-diarrheal & laxatives, anti-gas products & stomach remedies, anti-itch & insect bite treatments, baby rash ointments, cold sore remedies, cold/cough/flu/pain relief products, motion sickness, respiratory treatments, sleep aids/sedatives, etc. Some alternative treatments may require a letter of medical necessity from the patient's attending physician.* ★ *Hint: Check your drugstore website as many have online FSA sections that are excellent sources of information!*
Over-the-Counter Medical Items FSA☑	Complete FSA claim form and include: • Cash register receipt showing merchant name, date, product description and the dollar amount paid. ➔ ***Note:*** *Physician prescription is not required for items that are not a drug or medicine. Examples are bandages, birth control, braces & supports, catheters, contact lens supplies & solutions, denture adhesives, diagnostic tests & monitors, elastic bandages & wraps, first aid supplies, insulin & diabetic supplies, ostomy products, reading glasses, wheelchair, walkers, canes, etc.* ★ *Hint: Check your drugstore website as many have online FSA sections that are excellent sources of information!*
If Not Covered By Insurance	Complete FSA claim form and include an itemized statement clearly showing: 1. Provider name/address, 2. Date service was provided (not the date you paid for the service), 3. Patient name, 4. Description of service (eye exam, x-ray, crown); **and,** 5. Dollar amount you owe (regardless if paid). ★ *Hint: Your health care provider may not automatically provide an itemized statement, so you may need to ask for it.*
Orthodontia	Complete FSA claim form and include: • Payment coupon for monthly appointment; **or,** • Itemized statement and payment receipt if claiming one upfront payment (if allowed under your plan). ★ *Hint: Some employer plans have specific payment requirements. Check your plan for this information.*
Dependent Care (Work-related Child or Elder Daycare)	Complete FSA claim form and include: • Provider signature on the claim form; **OR**, • Itemized statement from provider showing: 1. Provider name/address, 2. Date the child/elder care services was provided, ➔ ***Note: Do not submit for services that have not yet been provided or future dates of service. Submit for a full month after the month has ended or submit for the previous week's expenses.*** 3. Name of dependent for whom the care was provided, 4. Type of service (daycare, day camp, preschool, after-school care, etc.); **and,** 5. Dollar amount you owe. Expenses must be work-related and for the care and well-being of the dependent. Expenses paid for overnight camp, lessons or classes to learn a specific skill or sport, educational sessions or classes are not eligible. ★ *Hint: Save time and paper by having your dependent care provider sign the claim form to certify the care was provided!*
	IRS rules are strict. Examples of unacceptable claim documentation are: • Cancelled checks, credit card receipts, or pre-treatment estimates of services to be provided in the future • Statements that are not itemized and say "balance forward" or "previous balance due" or "paid on account" • Statements for service that has not yet been provided, i.e., future dates of service • Statements that do not include the **date service was provided, description of service or provider name, patient name and dollar amount you owe** ★ *Hint: Just follow the guidelines above to ensure your claim is processed as quickly as possible.*

KEEP YOUR ORIGINAL DOCUMENTATION FOR YOUR RECORDS, AND SUBMIT A LEGIBLE COPY WITH YOUR CLAIM!
CLAIMS ARE NOT ACCEPTED BY EMAIL DUE TO PRIVACY/SECURITY CONCERNS.

★ ★ ★ **Go Green!** ★ ★ ★

Save the environment from unnecessary paper and receive communications and payment faster!
Here's how!

***Eliminate paper mail*! Sign up to receive notice of payments and account information via email or text alerts today!**
***Don't wait for a check in the mail!* Sign up to have payment sent directly to a bank account of your choice!**
***Eliminate manual claim filing!* File your claim via the Mobile App or online at www.asiflex.com for fastest service!**
***Have your dependent daycare provider sign the claim form!* If you do this, no other paperwork or documentation is necessary!**

Flexible Spending Account (FSA) Claim Form

NOTE: If you submit your claim online at www.asiflex.com, this form is not needed.

Your Name (Last, First, MI)	Social Security No. or EID or PIN	Your Employer Name
		STATE OF IOWA

Address	City	State	Zip Code

Dependent Care Flexible Spending Account Claims

Payment is allowed only for services **that have already been provided and not for services to be provided in the future.** You may submit for a full month **after** the month has ended or submit for the **previous** week's expenses. To substantiate your claim, submit an itemized statement from your provider or **simply have your provider(s) sign below to certify* the care was provided.** If your provider signs below, no other supporting documentation is required. Expenses must be incurred to allow you, and if married your spouse, to work; and must be for the care and well-being of the dependent. Expenses for overnight camp, lessons or classes to learn a specific skill or sport, educational sessions or classes are not eligible.

Name of Dependent	Age	Dates Care Was Provided No Future Dates MM/DD/YY thru MM/DD/YY	①Name/Address of Care Provider or Care Facility ②Type of Dependent Care Service (Daycare, Day Camp, Preschool, After School Care, etc.)		Amount Requested
			①		$
			②		
			①		$
			②		
			①		$
			②		
				Total	**$**

* Day Care Provider or Care Facility Certification:	* Day Care Provider or Care Facility Certification:
I certify that I provided dependent care services as detailed above.	**I certify that I provided dependent care services as detailed above.**
Print Name:_____	Print Name: _____
Original Signature: _____	Original Signature:_____
Date: _____	Date:_____

Health Care Flexible Spending Account Claims

Follow the instruction page "How to File Claims" and submit correct documentation to assure rapid claim processing!

Date(s) of Service	Health Care Provider	Type of Expense (Office Visit, Crown, Eyeglasses, Rx, etc.)	Patient Name	Relationship to You	Amount Requested
					$
					$
					$
					$
					$
					$
					$
				Total	**$**

I certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred by me, an eligible spouse, or an eligible dependent during a period while I was covered under my employer's FSA Plan and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. I certify any claimed Dependent Care expenses are work-related to allow me and, if married, my spouse to work, are primarily for the protection and well-being of my dependent and were provided for my dependent under the age of 13 or for my dependent who is incapable of self-care. I certify that any claimed Dependent Care expenses are not for overnight camp, lessons or classes to learn a specific skill or sport, or for educational sessions or classes. I understand that I am fully responsible for the accuracy of all information relating to this claim, and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense. A claim will only be processed with a completed and signed claim form and correct documentation. Claims are not accepted by email due to privacy/security concerns.

✔ Employee Signature_____ Date_____

FAX TO: 1-877-879-9038
PAGE_____OF _____
NO COVER PAGE REQUIRED

MAIL TO: ASI
PO BOX 6044
COLUMBIA, MO 65205-6044

FILE ONLINE: WWW.ASIFLEX.COM
NO CLAIM FORM NEEDED!
REV 10/2016