2600 West 49th Street
Sioux Falls, SD 57105-6575 **FLEX**

Phone: 1-800-325-5598
Fax: 1-605-336-0270
Email: flex@dakotacare.com

Flexible Spending Account (FSA) Reimbursement Request Form

Personal Information Company Name: ______________________

Name (Last, First, Middle Initial) | Street Address | City, State, Zip

Member ID/SS# | Daytime Phone | Email

PLEASE READ THE INSTRUCTIONS ON THE BACK OF THE FORM PRIOR TO COMPLETION

Health FSA

Summary of Expenses				**Dates of Service**		
Name of person receiving services	Relationship to Employee	Provider / Merchant	Service / Item Description	From Month/Day/Year	To Month/Day/Year	Amount to be Reimbursed
						$
						$
						$
						$
						$
					TOTAL:	$

Dependent Care FSA

Summary of Expenses			**Dates of Service**		
Name of person receiving services	Relationship to Employee	Day Care Provider / Facility	From Month/Day/Year	To Month/Day/Year	Amount to be Reimbursed
					$
					$
					$
					$
					$
				TOTAL:	$

** Provider Tax ID or SSN: ______________ Provider Address: ______________

IF NO DEPENDENT CARE FSA RECEIPTS ARE AVAILABLE, PLEASE HAVE DAY CARE PROVIDER SIGN HERE:

Provider Print Name | Provider Signature | Date (Include Year)

I certify that: 1) I have read the Summary Plan Description of the Flexible Spending Account Plan. 2) I have read the Instructions on the back of this form. 3) I have incurred these out-of-pocket expenses and have not previously requested payment for them from any other plan/source; The Health FSA expenses covered under this FSA Plan are submitted as un-paid or un-reimbursed by any other medical care plan available to me. 4) The above is a true and accurate statement of unreimbursed medical or dependent care expenses provided to me or my eligible dependents on the date(s) indicated. 5) I understand I am responsible for misrepresentation regarding requests for reimbursement.

Employee Signature | Date (Include Year)

NOTE: PLEASE SUBMIT ONLY *COPIES* OF YOUR RECEIPTS-SAVE YOUR ORIGINALS

Instructions:

1. All sections of the form must be completed.
2. Sign and date the claim form.
3. Attach supporting documentation for each claim.
4. Only itemized receipts and bills are acceptable proof of expenses (see documentation requirements below). **SUBMIT *COPIES* OF YOUR RECEIPTS: SAVE YOUR ORIGINALS**
5. Submit this form with your Itemized Statement/Bill/Receipt via one of the following methods:

Mail: DAKOTACARE
Attn: Flex Department
2600 West 49th St
Sioux Falls, SD 57105-6575

Fax: 605-336-0270, Attn: Flex Department

Email: flex@dakotacare.com

Online: www.dakotacareflexonline.com

Documentation Requirements:

Healthcare Flexible Spending Account - ***SUBMIT COPIES OF YOUR RECEIPTS: SAVE YOUR ORIGINALS***

- Name of employee or dependent receiving care
- Date(s) service was provided (must match claim form)
- Name of service provider
- Type of service provided
- Expense incurred
- Explanation of Benefits (EOB), if applicable, indicating the provider, date(s) of service, amount reimbursed and the amount outstanding
- If you are submitting receipts for prescriptions an Rx number or prescription from a licensed practitioner must be included with your documentation.

Dependent Care Flexible Spending Account - ***SUBMIT COPIES OF YOUR RECEIPTS: SAVE YOUR ORIGINALS***

- Name of dependent receiving care
- Date(s) service was provided (must match claim form)
- Name, address and Tax I.D. Number of service provider. Signature of Provider
- Dates of Service
- Expense incurred