DAKOTACARE ADMINISTRATIVE SERVICES, INC.

Flexible Spending Account (FSA)
Reimbursement Request

Employee Information

First Name_____ Middle Initial _____ Last Name_____

Address_____ City_____ State _____ ZIP_____

Phone_____ Social Security Number_____ Employer_____

Expenses

Complete the following and **attach an Explanation of Benefits and/or receipt noting the date of service, provider and amount of expense.** Reimbursement requests totaling less than $25 will be held until additional reimbursement requests have been received totaling $25 or more. All claims will be paid out by yearend.

NOTE: Balance forward statements, cancelled checks and credit card receipts are not sufficient documentation for reimbursement.

Unreimbursed Medical Expenses

Patient	Date of Service	Provider and Address	Amount

Dependent Daycare Expenses

Dependent	Date of Service	Provider Name and Address	Amount

Daycare Provider Signature _____ **Date** _____

I request reimbursement for the expenses listed above. I confirm that the services were received by the individuals listed on the dates described. I have attached the appropriate Explanation of Benefits and/or receipts. I accept full responsibility for the accuracy and sufficiency of these documents. I certify that these expenses were incurred while I was covered under my employer's Flexible Spending Account. I will not seek reimbursement from another health insurance plan. I understand that the Internal Revenue Code forbids me from claiming the above expenses as credits or deductions on my personal tax return.

After signing below, fax or mail the form to **DASFLEX**.

Employee Signature _____ **Date** _____

DASFLEX 5300 S Broadband Lane Sioux Falls, SD 57108
Phone: 605-322-4774 Fax: 605-504-9305 Toll-Free: 1-888-322-2115
Email: dasflex@averahealthplans.com

Discrimination is Against the Law

DAKOTACARE/DAS complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. DAKOTACARE/DAS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

DAKOTACARE/DAS:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact the DAKOTACARE/DAS Customer Service at 1-800-325-5598, (TTY 711), 8 a.m. to 5 p.m. CST, Monday through Friday.

If you believe that DAKOTACARE/DAS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Complaint and Appeals Coordinator
DAKOTACARE/DAS
5300 S Broadband Lane
Sioux Falls, SD 57108

Fax 1-605-274-3291
Email customer-service@dakotacare.com

You can file a grievance in person or by mail, fax, or email. You may also contact the Complaint and Appeals Coordinator if you need assistance with filing a complaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or call 1-800-368-1019 or 1-800-537-7697 (TDD). Or mail:
US Department of Health and Human Services,
200 Independence Avenue SW Room 509F, HHH Building,
Washington, D.C. 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

DAKOTACARE®

Getting Help in Other Languages

Language assistance services are available free of charge. Our Customer Service is available 8 a.m. to 5 p.m. CST, Monday – Friday, toll-free at 1-800-325-5598 (TTY: 1-800-877-1113).

- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-325-5598 (TTY: 1-800-877-1113).
- US CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-325-5598 (TTY: 1-800-877-1113).
- CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-325-5598 (TTY: 1-800-877-1113).
- XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-325-5598 (TTY: 1-800-877-1113).
- 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-325-5598 (TTY: 1-800-877-1113).
- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-325-5598 (TTY: 1-800-877-1113).
- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-325-5598 телетайп: (TTY: 1-800-877-1113).
- ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-325-5598 (رقم هاتف الصم والبكم: 1-800-877-1113).
- ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-325-5598 (TTY: 1-800-877-1113).
- ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အယိ. နမၤန့ၢ် ကျိာ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘၣ်သ့န့ၣ်လီၤ. ကိး 1-800-325-5598 (TTY: 1-800-877-1113).
- ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-325-5598 (TTY: 1-800-877-1113).
- 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-325-5598 (TTY: 1-800-877-1113) 번으로 전화해 주십시오.
- ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-325-5598 (መስማት ለተሳናቸው: 1-800-877-1113).
- OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-325-5598 TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-877-1113).
- ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-325-5598 (TTY: 1-800-877-1113).