



# Claim Form

Documentation requirements and instructions on next page.

Employee Last Name, First Name, MI (Please print)

Employer

Social Security Number or Employee I.D.

Street Address

City, State, ZIP Code

## Dependent Care Assistance Program

Dependent care expenses must be for a dependent who is incapable of self care or under age 13 when the care was provided.

Name of Dependent	Age	Dates Care Provided		Name, Address, and Taxpayer Identification Number of Care Provider	Cost for Care Period	ASI Use Only	
		From	To*				
<b>Total Dependent Care Amount Requested</b> →							

\*Claims for future services will not be accepted.

I provided the dependent care as stated above.

Care Provider's **Original** Signature

Date

SSN/Tax ID#

## Washington Flex (Health Care Flexible Spending Account)

Date Medical Care or Treatments Received	Provider Name	General Description of Medical Expense (include medical condition for over-the-counter items)	Patient Name	Relationship to Employee	Amount that is your responsibility	ASI Use Only	
<b>Total Amount Requested</b> →							

↑ Please attach your documentation in the order listed above.

I certify that all expenses that I am claiming reimbursement or payment for were incurred while I was enrolled as a PEBB eligible state employee in the Flexible Spending Account (FSA) program and/or Dependent Care Assistance Program (DCAP). I have not been reimbursed for these expenses, nor will I seek reimbursement from any other source. The dependent care expenses reported above were provided for my dependent who is under the age of 13 or incapable of self care. I understand that I am fully responsible for the accuracy and completeness of all information relating to the claim(s) above. If an expense listed above does not qualify for reimbursement, I understand I may be liable to pay taxes on any amounts that ASIFlex pays for that expense.

Employee's Signature

Date

Mail or fax (with supporting documentation) to: ASIFlex, P.O. Box 6044, Columbia, MO 65205-6044  
Toll-free fax: 1-877-879-9038

## Claim Filing Requirements

1. **Print your name, employer's name, your social security number (SSN) or employee I.D., and your street address.**
2. **List expenses by date and arrange the supporting documents in the same order.**  
Circle the service dates on your documentation. If you have several statements from the same provider, you may subtotal them and list them on one line with a range of dates.
  - Day care claims - Complete the Dependent Care Assistance Program section.
  - Health care claims - Complete the Health Care Flexible Spending Account section. (The amount column should be the amount you are requesting after any insurance payment or provider discount for each expense).
  - Copy the form if you need to list more items.
3. **Enclose required documentation.\*** A written statement from the dependent care or medical provider (doctor, hospital, pharmacy, etc.) of the service or an insurance company benefits statement showing all of the following:
  - The name of the dependent care or medical service provider.
  - The date(s) of medical service or day care. Although this date may be the same as the date paid it must be clear on what date the service was provided. The services must have already been provided.
  - A description of the service provided (for example, for health care, "dental cleaning", or for day care, "day care").
  - The name(s) of the person(s) receiving the medical or dependent care.
  - The cost of the service, not just the amount you paid.

*\* **Dependent care claims only** - You may either provide documentation from the day care provider **or** have the provider complete the Dependent Care Assistance Program section, then sign on the Care Provider's Signature line and date the signature. You do not need to do both.*

Requests filed without the above documentation **cannot** be processed and will be returned to you.

4. **Sign** the claim form.
5. **Keep copies** for your tax records.
6. **Fax toll-free to 1-877-879-9038 or mail to the address on the first page of this form.**

### **Over-the-counter medicines & drugs:** Additional filing requirements under the Health Care FSA:

- The receipt or documentation from the store must include the name of the drug printed on the receipt. This information must be provided by the store, not just listed by the participant on the receipt or on the claim form.
- You must indicate the existing or imminent medical condition on the receipt, claim form, or on a separate enclosed statement each time these items are claimed. Purchases for general good health are not accepted.

**Orthodontics:** Requests may be reimbursed as payments are made to your orthodontist. In order to be reimbursed, the braces must have been placed (or the initial work provided) and must still be on the patient. You must submit a copy of your treatment plan (sometimes called your contract) with your provider that lists the total amount for which you are responsible and the treatment period. You must submit proof of payment with your reimbursement request. The proof of payment can be a paid receipt from your provider, a credit card receipt or your credit card statement.

**Medical equipment, vitamins, herbs and nutritional supplements, health club or weight-loss programs, procedures or purchases normally deemed cosmetic, massage therapy, etc.:** To claim these items, you must submit a letter from your physician every 12 months stating the nature of your medical condition, the specific item or service needed, and that it is needed for the treatment of this condition.

**Claim forms:** You may copy this form, obtain forms on the Internet at [www.asiflex.com/pebb](http://www.asiflex.com/pebb), or call ASIFlex at 1-800-659-3035.

**Account detail available 24 hours a day, 7 days a week:** Complete history including claims, elections, and available funds on the Web at [www.asiflex.com/pebb](http://www.asiflex.com/pebb) (Account Detail). You will need your P.I.N., which you can find on your enrollment confirmation.

**Address changes:** Addresses are **not** updated from this claim form. Please change your address on file with your employer **and** send a letter or e-mail to ASIFlex.