



Claim Form

Documentation requirements and instructions – See back side

Fax to:
 ASIFlex
 (866) 381-9682
 No Cover Page Required
 Page 1 of ____

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*				
Total Dependent Care Amount Requested →							

*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 Provided*	Name of Medical Provider	General Medical Expense Description (include medical condition for over-the-counter items)	Patient Name	Relationship	Amount that is your responsibility	ASI Use Only	
Total Medical Amount Requested →							

↑
Please arrange documentation in order listed above.

I certify that all expenses that I am claiming reimbursement or payment for were incurred while I was enrolled in the State of Washington's 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 ASI pays for that expense.

Employee's Signature

Date

**Mail or fax (with supporting documentation) to: ASI, P. O. Box 6044, Columbia, MO 65205-6044
Toll-free fax: 1-866-381-9682**

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 or range of dates 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 of the person or persons receiving the medical or dependent care.
 - The cost of the service, not just the amount 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 1-866-381-9682 or mail to the address on the front 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 for a reasonable monthly payment (approximating the monthly service value) on or after the payment is due and paid. You may only file claims for orthodontic payments while treatment is in process with a paid receipt from your orthodontist or a photocopy of the monthly coupon/invoice and your check. Pre-payments are not allowed. You must submit a written statement from the orthodontist showing the charge for the initial installation work, when it was completed, and a paid receipt for an initial down payment or appliance fee.

Physician letter required for 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 equipment or item needed, and that it is essential to the treatment of this condition.

Claim forms: You may copy this form, obtain forms on the Internet at <http://pebb.asiflex.com>, or call ASI 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 <http://pebb.asiflex.com> (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 separate notice to ASI.