STATE OF OREGON FSA CLAIM FORM

Documentation Requirements & Instructions – See back side

Fax to:
ASIFlex
(877) 879-9038
No Cover Page Required

_____ P _____

Last Name, First Name, MI (Please Print) PEBB-assigned ID (P + 8 digit ID)

_____ _____

Street Address City, State, Zip

Dependent Care Flexible Spending Account (day care, babysitting, etc.)

Dependent care expenses must be for a dependent who is incapable of self care or under the age of 13 at the time 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 →			0.00		

I provided the dependent care as stated above. _____ _____ _____

Care Provider's **original** signature Date SSAN/Tax ID#

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	Relation-ship	Amount that is your responsibility	ASI use only	
	Total Medical Amount Requested →				0.00		

Please arrange documentation in order listed above**.**

***Claims for future services will not be accepted**.

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under his/her employer's Flexible Spending Plan with respect to such expenses and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. Any Dependent Care expenses claimed here were provided for my dependent under the age of 13 or for a dependent who is incapable of self care. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned 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.

_____ _____

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, address, and P number (your state-assigned employee identification number).***

2. ***List expenses by date & arrange the supporting statements 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 Flexible Spending Account (FSA) section
   - Health care claims - complete the Health Care Flexible Spending Account (FSA) section (The amount column should be the amount you are requesting after any insurance payment or provider discount for each expense).

3. ***Enclose required documentation**.*** A written statement from the dependent care or medical (Dr., hospital, pharmacy, etc.) provider 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, and
   - 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 Flexible Spending Account Section, then sign on the "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.

4. ***Sign*** the claim form.

5. ***Keep*** copies for your tax records.

6. ***Fax toll-free to 1-877-879-9038 or mail to P O Box on the front of this form***.

Over-the-counter medicines & drugs: Effective January 1, 2011, over-the-counter (OTC)medicines will not be reimbursable unless you have a valid prescription. Insulin still qualifies for reimbursement without a prescription. Equipment, supplies, and diagnostic devices such as bandages, hearing aid batteries, blood sugar test kits, etc. will remain eligible for reimbursement without a prescription. Please refer to ASIFlex's website, http://www.asiflex.com, for a list of OTC medicine categories that no longer qualify for reimbursement without a prescription after January 1, 2011. To claim vitamins, herbs or nutritional supplements, you must have a written diagnosis of the medical condition and "prescription" of all specific items for that condition on file with the claims office.

Orthodontics: Requests may be reimbursed for amounts that have been 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 coupon, invoice or contract and your proof of payment.

Physician Letter Required for: Medical equipment, vitamins, herbs & nutritional supplements, health club or weight loss programs, procedures or purchases normally deemed cosmetic, massage therapy, etc.: To claim these items, a letter from a physician must be on file, updated 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 stated condition.

Claim forms: You may copy this form, obtain forms on the Internet at http://www.asiflex.com, or call ASIFlex at 1-800-659-3035 and request additional claim forms.

Account detail available 24 hours a day 7 days a week: - Complete history including claims, elections & available funds *on the Web* at www.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 & enclose a separate notice to ASIFlex.