



STATE OF OREGON FSA CLAIM FORM
Documentation Requirements & Instructions - See back side

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.

Table with 6 columns: Name of Dependent, age, Dates Care Provided (From, To), Name, Address, and Taxpayer Identification Number of Care Provider, Cost for Care Period, ASI use only. Includes a Total Dependent Care Amount Requested row at the bottom.

I provided the dependent care as stated above.

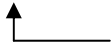
Care Provider's original signature

Date

SSAN/Tax ID#

Health Care Flexible Spending Account

Table with 7 columns: Date Medical Care Provided, Name of Medical Provider, General Medical Expense Description, Patient Name, Relationship, Amount that is your responsibility, ASI use only. Includes a Total Medical Amount Requested row at the bottom.



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.

Employee's Signature

Date

ASIFlex
P. O. BOX 6044
COLUMBIA MO 65205-6044
Toll-Free Fax: 1-866-381-9682

Mail or FAX to ASI ALONG WITH SUPPORTING DOCUMENTATION
E-mail: asi@asiflex.com
Internet http://www.asiflex.com/orpebb

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 1-866-381-9682 or mail to P O Box on the front of this form.**

Over-the-counter medicines & drugs: Additional filing requirements for plans allowing these 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.
- The participant must indicate the existing or imminent medical condition on the receipt, on the claim form, or on a separate enclosed statement each time these items are claimed. Purchases for general good health will not be accepted.

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.