INDIANA UNIVERSITY

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FSA CLAIM FORM

Reimbursement of Payment Request

Employer Name

Employee Information

Name (Last, First, Middle Initial)

Employee ID Number

Address (Street)

Address (City, State, Zip) ☐ **Check Here If New Address**

Employee Email Address

Names of Dependents

(For whom expenses are currently being submitted.)

Dependent Name	DOB	Relationship

I hereby certify that the information on this claim form is correct and authorize release of payment through my reimbursement account. I understand that reimbursement is not a guarantee that this payment is tax exempt. I have not received and will not receive reimbursement for these expenses from this or any other plan. The total of reimbursed dependent care expenses for the plan year does not exceed my or my spouse's earned income (W-2 pay) for the year. I understand that reimbursed dependent care expenses cannot be used to claim a credit on my personal income tax return.

Employee Signature

Date

Where To Send a Claim:

Mail: IU HSA/FSA
P.O. Box 2905 Fargo, ND 58108-2905

Email: IUSupport@wexinc.com from your IU email with [Secure Message] in the subject line

Fax: 1-888-887-9961

Phone: 1-800-284-8412

Expenses to be Reimbursed

☐ Health Care

*Expenses must be ineligible or non-reimbursed by medical/dental plan.
*The service must be provided while participating in the plan.
*The claim must be submitted during the claim eligibility period.

	Type of Expense	Date Incurred	Amount
Medical			
			$
			$
			$
			$
		Total	$
Dental			
			$
			$
			$
			$
		Total	$
Vision			
			$
			$
			$
			$
		Total	$
Other			
			$
			$
			$
			$
		Total	$

☐ Dependent (Child) Care

*Expenses must be considered to be for the care of the child.
*Expenses may not be used to claim a credit on personal income taxes.
*The claim must be submitted during the claim eligibility period.

Type of Expense	Date Incurred	Amount
		$
		$
		$
		$
	Total	$

Dependent Care Provider

Name

Address

Tax ID Number or SSN for Individuals

Instructions for Filing a Claim

- For medical/dental/vision expense claims that were submitted to a health plan or an insurance company but were not fully paid by that carrier, **please attach copies of the insurance carrier claim and/or payment form such as an Explanation of Benefits (EOB)** to establish the amount not covered under the medical/dental/vision plan.
- For all other reimbursable expenses, the copies of all itemized bills must be attached. **These must list name and address of the service provider, the date(s) of service, the service provided, and the patient responsibility.**
- Please be aware canceled checks alone are not acceptable receipts.
- For all dependent care expense, the copies of paid receipts must be attached. **These must include the name and address of the service provider, the date(s) of service, the service provider, and fee for the service.**
- PLEASE DO NOT HIGHLIGHT receipts.
- **The Claim Form must be complete, including Participant signature and date.**
- **Please keep original documents for your records and mail in copies.**