



FIFTH THIRD BANK

Flexible Spending Account (FSA) Claim Reimbursement Request Form



Company Information (PLEASE PRINT)

Company Name	Division (if applicable)
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Participant Information (PLEASE PRINT)

Last Name	Primary Phone	
First Name	Secondary Phone	
SSN / (or Alternate Employee ID)	Date of Birth (mm/dd/yyyy)	Email Address (For Account Notifications)
Street Address (Check if New Address <input type="checkbox"/>)		
City	State	Zip

If your claim includes expenses incurred by a spouse or eligible dependents, please provide the following information:

Dependent Name	Relationship	Date of Birth

Reimbursement Request (PLEASE PRINT)

Please indicate your eligible expenses below. **DO NOT include expenses reimbursed by any other source.**

HEALTHCARE – FLEXIBLE SPENDING ACCOUNT (FSA)

Attach copies of bills, receipts, Explanation of Benefits (EOBs) or other claim documentation. Documentation must include dates of service, description of service and the expense amount. Cancelled checks and/or credit card statements/receipts are NOT sufficient proof of your claim.

Date Range of Services	From	through	TOTAL Healthcare Reimbursement Request
Description (Please list a brief description of services below – ie: Prescription, copay, contact solution, etc...)			
IMPORTANT: If this is a Limited Healthcare Flexible Spending Account - Submit claims only for dental and/or vision expenses			\$ _____ (REQUIRED)

DEPENDENT DAYCARE – FLEXIBLE SPENDING ACCOUNT (FSA)

The following information is **REQUIRED**: Business name; dates of service and the expense amount; either a receipt/bill OR your provider's signature below. **NOTE:** Cancelled checks are acceptable for daycare expenses only; credit card statements/receipts are NOT sufficient proof of your claim.

Date Range of Services	From	through	TOTAL Dependent Daycare Reimbursement Request
Provider's Tax ID or SSN	Provider's Business or Name		
Dependent Daycare Provider's Signature:			\$ _____ (REQUIRED)

Claim Certification

To the best of my knowledge and belief, my statements on this form are complete and true. I certify that my family member or I have received the services described above on the dates indicated and that the expenses qualify as valid medical expenses under the plan. I certify that these expenses have not been reimbursed under any other plan, nor will I seek reimbursement for any of these expenses elsewhere. I understand that these expenses may not be used to claim any Federal income tax deduction or credit. **Any person who, with intent to defraud or knowing they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud or healthcare fraud under state and/or federal law.**

Participant Signature (Required)	Date
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SEND THIS FORM TO CHARD SNYDER

Please submit this form to Chard Snyder by one of the three methods listed to the right

Fax: 888.245.8452 *(Please DO NOT include a Fax Cover Page)*
 Mail: 6867 Cintas Boulevard, Mason, OH 45040
 Email: 53askpenny@chard-snyder.com

Classification: Internal Use

Flexible Spending Account Claim Reimbursement Instructions

- Complete all company and employee information** on the front page (please print/type). NOTE: Please include your e-mail address to receive an automatic e-mail notification whenever a claim is entered into our system and when a reimbursement is approved for you to receive payment.
- Attach supporting documentation.** A copy of a receipt or EOB must accompany this request for each claim submitted for reimbursement. *Do not highlight any part of your receipt.* Be sure to keep your original receipts, bills, etc. for your records. All receipts are destroyed daily. Each claim request must include the following information to be eligible for reimbursement:
 - Original date of service (not the date of payment)
 - Description of service performed (refer to list of eligible expenses to identify valid services)
 - Provider's name and address (If submitting receipts for dependent daycare expenses)
 - Amount charged to you (do not include amounts reimbursed by another source)
- Healthcare – Flexible Spending Account Reimbursement Request:** Complete all required information (*i.e.: Total Reimbursement Request Amount*) and attach proof of expense as described above. *Cancelled checks are NOT acceptable as proof of payment. Limited healthcare Flexible Spending Accounts may only reimburse claims for dental and/or vision expenses.*
- Dependent Daycare – Flexible Spending Account Reimbursement Request:** Complete all required information (*i.e.: Total Reimbursement Request Amount*) and attach proof of expense as described above. *Note: Cancelled checks are acceptable as proof of payment.*
- You MUST sign and date** the 'CLAIM CERTIFICATION' section on the front of this page.
- Fax, Mail or Email** this form and supporting documentation directly to Chard Snyder:
 - Fax:** 888.245.8452 (*Please DO NOT include a Fax Cover Page*)
 - Mail:** 6867 Cintas Boulevard, Mason, OH 45040
 - Email:** 53askpenny@chard-snyder.com
- If you have questions please contact us:
 - Call Customer Service:** 888.350.5353
 - Visit our website:** www.53hsa.com
 - Email your questions:** 53askpenny@chard-snyder.com
- Important reminders:**

All requests are saved as electronic images. To ensure your claim is processed as soon as possible, and avoid delays:

 - Do NOT use a fax cover page when faxing
 - Do NOT highlight any part of your receipts, bills, etc.
 - Only send copies of receipts, bills, etc. (Keep your originals)
 - Multiple receipts should be totaled on one claim form
 - Payments are issued after receipt and processing, subject to claim approval
 - Claims may not be paid across accounts (healthcare from dependent daycare and vice versa)
 - Any items for which you are reimbursed cannot be claimed again as deductions or credits on your individual tax return at the end of the tax year
 - Dependent daycare claims may only be reimbursed for the amount you have in your account at the time of your claim. If your claim is for more than the balance in your account, the rest of your claim will be paid when more money is added
 - You may only be reimbursed for eligible expenses incurred during the current plan year
Note: Orthodontia expenses are reimbursed as designated by the provider
 - Payment will be made directly to you. Payments cannot be made to a provider or another person

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