Flexible Spending Account (FSA) Claim

Instructions for Completing and Submitting this Form

There are six steps to completing this form.

1. Complete Section 1, *Employee Information.*
2. Complete Sections 2 and/or 3.

   List expenses by date and 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.
   - For day care claims, complete ***Section 2: Dependent Care Assistance Expenses***.
   - For health care claims, complete ***Section 3: Unreimbursed Medical Benefit Expenses***. The amount column should be the amount you are requesting after any insurance payment or provider discount for each expense.
3. Enclose the required documentation*.

   Documentation should be a written statement from the dependent care or medical (e.g., doctor, hospital, pharmacy) 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 the 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 service must have already been provided.
   - A description of the service provided, such as, "dental cleaning" for medical care expense, or "day care" for day care expense.
   - The name of the person or persons receiving the services or dependent care.
   - The cost of the service, not just the amount paid.

   * ***Dependent Care claims only***, you must either provide documentation from the day care provider, or have the provider complete Section 2, including the Provider Attestation. You do not need to do both.

   Claims submitted without the above documentation cannot be processed and will be returned to you.
4. Sign the claim form.
5. Keep a copy of the claim form for your tax records.
6. Submit the completed claim with all supporting documentation to:

   Mail: MVP FLEXIBLE BENEFITS DEPT
   PO BOX 2207
   SCHENECTADY NY 12301-2207

   Fax: **315-234-6146**

   Email: **myspendingaccounts@mvphealthcare.com**

   Online: Scan and upload your claim at **mywealthcareonline.com/mvphealthcare**

Over-the-Counter Medications

There are additional filing requirements for plans allowing over-the-counter medications under the medical FSA:

- The receipt or documentation from the store must include the name of the medication printed on the receipt. This information must be provided by the store, not just listed on the claim form.
- 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 MVP. You must renew this physician notice every 12 months and file it with MVP with the first claim submitted for those items each plan year.

Orthodontics

Requests may be reimbursed for a reasonable monthly payment on or after the payment is due and paid. The payment must be a reasonable approximation of the value of each month's service. You may only file claims for orthodontic payments while treatment is in process. You must submit a paid receipt from your orthodontist or a photocopy of the monthly coupon 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 to claim an initial down payment or appliance fee.

Medical Equipment

Medical equipment claims require a letter from a physician every 12 months stating the nature of your medical condition, the specific equipment needed, and that the equipment is essential to the treatment of the condition.

Claims payment and account information are available 24 hours a day, seven days a week.

A complete history, including available funds, can be accessed by visiting **mywealthcareonline.com/mvphealthcare**.

Questions? We're here to help.
Call **1-888-222-9931** for assistance or email **myspendingaccounts@mvphealthcare.com**.

Flexible Spending Account Claim

for Dependent Care Assistance and Unreimbursed Medical Benefit Expenses

MVP HEALTH CARE

Section 1: Employee Information *(please print)*

Employee Name *(Last, First, Middle Initial)*	Employee Social Security No. or MVP Subscriber ID (EID) *(as appropriate)*	Employer Group No.

Address	City	State	Zip Code
		NY	

Section 2: Dependent Care Assistance Expenses (Day Care, Babysitting, etc.) *(please print)*

Dependent care expenses must be for a dependent who is incapable of self care, or who is age 12 or under at the time the care was provided.

Dates Care Provided From	To†	Dependent Name	Age	Name, Address, and Taxpayer ID No. or Social Security No. (SSN) of Care Provider	Cost for Care Period	MVP Use Only
					$	
					$	
				Total Dependent Care Amount Requested ▶	**$ 0.00**	

† *Claims for future services are not eligible for reimbursement.*

Care Provider's Attestation: *I provided the dependent care as listed above.*

Care Provider's Original Signature | Date | Taxpayer ID No. or SSN

Section 3: Unreimbursed Medical Benefit Expenses *(please print)*

Date Medical Care Provided*	Patient Name	Relationship to Employee in Section 1	Medical Provider Name	General Medical Expense Description *(Include medical condition for over-the-counter items)*	Amount That is Your Responsibility	MVP Use Only
		☐ Self			$	
		☐ Self			$	
		☐ Self			$	
				Total Medical Reimbursement Amount Requested ▶	**$ 0.00**	

* *Arrange documentation in the same order as listed.*

Please submit a **detailed statement of services** or an **insurance Explanation of Benefits (EOB)** statement for each expense listed above. Credit card receipts or statements with a previous balance are not sufficient documentation.

As a participant of the Plan, I certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while I was covered under my employer's Flexible Spending Plan and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. Any claimed Dependent Care Assistance expenses were provided for my dependent age 12 or under, or for any dependent who is incapable of self care. I understand that I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, I 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 Signature | Date

See page 1 for instructions and how to submit this completed form and documentation.

Total number of pages submitted

Need additional forms? Photocopy this form or download it at **mywealthcareonline.com/mvphealthcare**.