



## Miami-Dade County SPENDING ACCOUNT • REIMBURSEMENT REQUEST FORM

PLEASE READ THE INSTRUCTIONS ON THE BACK OF THIS FORM PRIOR TO COMPLETION.  
KEEP A COPY OF THIS FORM FOR YOUR RECORDS. SEND COPIES OF ORIGINAL RECEIPTS.

A. NAME \_\_\_\_\_ HOME PHONE (        ) \_\_\_\_\_ DAY PHONE (        ) \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 SOCIAL SECURITY NO. \_\_\_\_\_ EMPLOYER \_\_\_\_\_

B. HEALTH CARE SPENDING ACCOUNT								
Do you have coverage for medical expenses?			Yes <input type="checkbox"/>	No <input type="checkbox"/>	Was the amount applied to your deductible:		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is your medical coverage provided through an HMO plan?			Yes <input type="checkbox"/>	No <input type="checkbox"/>	Was the amount you paid a co-payment?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is any portion of the service covered by your medical coverage?			Yes <input type="checkbox"/>	No <input type="checkbox"/>				
SUMMARY OF EXPENSES					Dates of service **			
Name of person receiving services	Relationship to employee	Provider of services*	Deductible or Co-Pay	From Mo/Day/Yr	To Mo/Day/Yr	Amount to be reimbursed		
<b>TOTAL</b>								

\* "Provider" means hospital, doctor, dentist, drugstore, medical supply store, etc.  
 \*\* Use date on which service was provided, not the date you paid for it.

FOR OFFICE USE ONLY                      DATE                      AUTHORIZATION #                      INITIAL

C. DEPENDENT CARE SPENDING ACCOUNT							
Is the facility Tax Exempt?***		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Tax ID# or social security # of Day Care provider			
SUMMARY OF EXPENSES				Dates of service **			
Name of person receiving services	Age and grade	Relationship to employee	Provider of services* and address	From Mo/Day/Yr	To Mo/Day/Yr	Amount to be reimbursed	
<b>TOTAL</b>							

\* "Provider" means day care center, person who gave care, etc.  
 \*\* Use date on which service was provided, not the date you paid for it.  
 \*\*\* If the facility is Tax Exempt, the I.D. Number is not required.

SIGNATURE OF DAY CARE PROVIDER \_\_\_\_\_

The above is a true and accurate statement of unreimbursed medical or dependent care expenses provided to me or my eligible dependents on the date(s) indicated. I have read and understand the information on the back of this form. I understand that I am responsible for misrepresentation regarding requests for reimbursement.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_                      FOR OFFICE USE ONLY                      DATE                      AUTHORIZATION #                      INITIAL

# INSTRUCTIONS FOR FSA REIMBURSEMENT

(To assure the quickest turnaround and best service, please read these instructions carefully.)

## General FSA Reimbursement Request Instructions

- Contact FBMC Customer Service at 1-800-342-8017 to request information or assistance.
- **FSA Reimbursement Request Forms will be returned unprocessed if the instructions on this form are not followed.**
- Refer to your Employer's current plan year Enrollment Booklet for information on participation rules, expense eligibility, type of supporting documentation required, and other guidelines.
- To request reimbursement of an eligible FSA expense, supporting documentation is required with your reimbursement request and described further in the instructions under each section below.
- You must maintain copies of the information and documentation you submit for all reimbursed FSA expenses to respond to any IRS inquiries you may receive.
- Cancelled checks and charge receipts (or copies) are not acceptable receipts by the IRS to support the reimbursement of FSA expenses.
- You may not request reimbursement until services have been provided, regardless of when you paid for the service.
- IRS regulations provide that any unused funds that remain in an FSA after a plan year ends (and all reimbursable FSA requests have been submitted and processed) cannot be returned to you nor carried forward to the next plan year but will be forfeited to your Employer.
- If dates of provided services begin in one plan year and end in the next plan year, and you are enrolled in the FSA both plan years, you must submit a separate FSA Reimbursement Request Form for each plan year in which the services were provided.
- Information on any grace period within which you may submit eligible FSA expenses incurred during your period of coverage within a plan year can be found in the "FSA Guidelines" section in your Employer's current plan year Enrollment Booklet.
- Your supporting documentation must be legible.
- You must read over your FSA Reimbursement Request Form to ensure that you have signed, dated and completed it, and attached any required supporting documentation.
- You may access your personal FSA information or request FSA Reimbursement Request Forms, 24 hours each day, by calling FBMC's Interactive Benefits Information Line at 1-800-865-3262.

## Additional Medical Expense FSA Reimbursement Request Instructions

- Make sure you complete Section B in its entirety.
- To request reimbursement of an eligible HCFSFA expense, the following minimum supporting documentation is required: a copy of a receipt, invoice or bill from the provider showing the date service(s) were received, the cost of the service(s), the type of service(s) incurred, and the name of the IRS-eligible person(s) for whom the service(s) were provided.
- Caution: IRS Pub. 502 is intended to help you decide what expenses are deductible on Schedule A to IRS Form 1040. No portion of IRS Pub. 502 should be relied upon to help you decide what expenses are reimbursable under an HCFSFA plan.
- The IRS requires the complete name of all drugs be obtained and documented on pharmacy receipts.
- If the medical coverage is not provided through an HMO, you must attach an Explanation of Benefits (EOB) from the health insurance provider showing the date service(s) were received, the cost of the service(s), the type of medically necessary service(s) received, the name of the IRS-eligible person(s) for whom the service(s) were provided, and any uninsured portion of the cost.
- Some capital expenditures may qualify as medical care under IRC § 213. General rules for capital expenditures that could be reimbursable are: (i) a special version of an otherwise personal item can be reimbursed to the extent of the increased cost; (ii) an item permanently attached to a dwelling can only be reimbursed to the extent that its cost exceeds the increase in value; (iii) if there is no personal element and the item is not attached to a dwelling, it must only be used by the person for whom the medical need has been determined; but (iv) if the item is used by others as well, only a prorated amount of the entire cost can be reimbursed.
- Reimbursement of the cost of certain capital expenditures may require (i) a Letter of Medical Need from the treating healthcare provider, (ii) a personal use letter signed by the patient, and (iii) a capital expense appraisal letter.<sup>1</sup>
- Some provided medical treatments and services, including those that could be deemed personal or cosmetic, require a Letter of Medical Need from the treating healthcare provider.<sup>1</sup>
- The standard mileage rate reimbursable for use of an automobile to obtain medical care is subject to IRS change annually.<sup>1</sup>
- <sup>1</sup>Visit FBMC's Web site at [www.myFBMC.com](http://www.myFBMC.com), or call FBMC Customer Service at 1-800-342-8017 for more information or to obtain letter samples.

## Additional Dependent Care FSA Reimbursement Request Instructions

- Make sure you complete Section C in its entirety.
  - To request reimbursement of an eligible DFSA expense, you must submit a copy of a receipt, invoice or bill from the provider showing the name and address of the provider showing the beginning and ending dates of the provided services, the cost of the service(s), the age and grade, and the name of the IRS-eligible person(s) for whom the service(s) were provided.
  - Dependent care expenses must be provided to allow you and your spouse (if married) to work or actively look for work. Your spouse is considered working (i.e., gainfully employed) if, among other requirements, he or she is a full-time student at an educational organization, or physically or mentally incapable of self-care.
  - Reimbursement can only be made for eligible expenses incurred for the dependent care of one or more qualifying individuals who reside in your household, at least eight hours a day.
  - A qualified person is your tax dependent age 12 or younger, or your spouse or tax dependent who is physically or mentally incapable of self-care.
  - FBMC is unable to issue payment on approved reimbursement requests until after the last date of service for which you are requesting reimbursement.
  - For timely processing of your request, your payroll contributions must be current.
  - The amount of reimbursement requested on this form, added to the dependent care expenses reimbursed to date from any other source or plan, cannot exceed the statutory limits based upon your tax filing status.
  - Payments for dependent care cannot be made to you, your spouse, or someone you or your spouse claim as a tax dependent.
  - Educational expenses incurred for a child in kindergarten and up are not reimbursable. The cost of dependent care before and after school is reimbursable.
  - Tuition is not a reimbursable expense.
  - Expenses such as registration fees, activity fees, books, supplies and meals are not reimbursable.
- Mail or Fax a copy of this form to:  
**Fringe Benefits Management Company (FBMC)**  
Post Office Box 1800  
Tallahassee, FL 32302-1800  
**Customer Service: (800) 342-8017 Toll Free Fax: (866) 440-7154**  
**Interactive Benefits Information Line: (800) 865-3262**
- If you fax your reimbursement request to FBMC, retain a copy for your records. Do not mail the copy of your faxed transmittal to FBMC.**