Received Date

Freedom Services, Inc.
Benefits Administration Services

Processed By:_____

For FSI Use Only

FSA CLAIM FORM

Employee: _____

Social Security #: _____

Employer: _____

Home Address: _____

☐ Address Change _____

keep copies of claim form and documentation for your personal records

Claims may be submitted in three ways:

- Faxed to: **952.895.4056**
- Emailed to: **claims@freedomservices.com**
- Mailed to: **Freedom Services, Inc.**
  PO Box 3110, Burnsville, MN 55337-8110

IMPORTANT - To Request and Receive Reimbursement:

1) Complete the entire claim form, including signature and date. Failure to **complete the form in its entirety** and attach appropriate documents will result in a delay in processing your claim. Writing "see attached" with documents attached will not be accepted.

2) Documents from a third party must include the provider name, date of service, description of service, cost of service and amount not covered by insurance. An Explanation of Benefits from your insurance company is preferred. If documents do not contain sufficient information to process the claim, additional information will be requested. Prescription drug claims must provide the Rx number, the fill date and the cost of the drug. Send prescription receipts, not cash register receipts. Orthodontia expenses should be submitted on the Orthodontia Reimbursement Procedures Provider Form from Freedom Services.

3) Claims may be mailed, faxed, or emailed. *If you fax or email your claims, you are waiving your HIPAA privacy rights for the claims listed.*

4) Keep a copy of the claim form and all supporting documentation for your personal records - if claims are faxed or emailed, you do not need to send hard copies by mail.

HEALTH and DEPENDENT CARE FLEXIBLE SPENDING ARRANGEMENTS

Please complete a separate line for each expense. Use additional forms if necessary. **ALL INFORMATION MUST BE FILLED OUT COMPLETELY**. The receipt must show a detailed description of the services provided. Credit card slips, canceled checks, balance forward, balance due, or payment on account statements are not acceptable documentation. Services have to be fully rendered before reimbursement can be made; i.e., prepaid dependent care expenses will not be reimbursed until the service has been provided.

Eligible Expense Amount	Type of Service (Medical/Dental/Vision/Rx or Dependent Care *)	Service Dates (not date paid or billed) From: mm/dd/yy	To: mm/dd/yy	Service Provider's Name (Tax ID or SSN is Required on Dependent Care Documentation)	Name of Person Receiving Service Must be a 1040 Tax Dependent	Office Use Only
$						A
$						B
$						C
$						D
$						E
$						F
$						G
$						H
$						I

$ _____ **Total Expenses** ☐ **Expenses Paid With The FreedomCard Debit Card**

DEPENDENT CARE - This Section is Required for Dependent Care Only

Dependent Care Provider's Signature | **Federal Tax ID or Social Security #** | **Date**

Signature certifies that services listed above have been rendered and paid for. (Necessary only if a receipt is not provided)
*Child Care is for persons under age 13, Adult Care is for IRS Qualified persons 13 years or older.

Certification and Acknowledgement: Reimbursement will be made in accordance with all Plan guidelines. The above expenses were incurred by my eligible dependents and/or myself during my FSA Plan Year. I have not and do not expect to be reimbursed for these expenses by any other source. Reimbursement is being requested after all other benefit payments from all other available plans have been completed. These expenses will not be deducted on my individual income tax return. Dependent care expenses meet the Internal Revenue Code definition of Dependent Care. I accept responsibility for the proper treatment of benefits paid under the Plan with respect to eligibility, income tax reporting and liability.

Employee's Signature *(unsigned claim forms will be returned unprocessed)* **Date**