Flexible Spending Account (FSA)

Reimbursement Claim Form

BASIC pacific

Page ___ of ___ *(including this claim form)*

Employer: ______________________

FAX TO: (916) 303-7083 or (800) 584-4591
EMAIL TO: customerservice@basicpacific.com

Employee Name: ______________________ Social Security Number: ______________________

Phone: ______________________ E-mail: ______________________

Dependent Care Expense Claims

Name & Date of Birth of Dependent(s)	Period Covered From	To	Name, Address, and Taxpayer Identification Number (or SSN) of Service Provider	Amount Incurred
☐ *Attach a receipt from your daycare provider, or include the daycare provider's signature.*			**Provider's Signature:**	
			Total Dependent Care Expense Claim*	**$**

*NOTE: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the Plan Year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of $250 if there is one (1) child or dependent, or $500 if there are two (2) or more.) No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes; or is your child or stepchild and is under age 19.

Medical Expense Claims

Date Expense Incurred (mm/dd/yyyy)	Name of Service Provider	Expense Description (Medical, Dental, Vision, Rx, OTC, etc.)	Person for Whom Expense was Incurred	Net Amount
☐ *Attach appropriate receipt(s) and submit with this claim form.*			**Total Medical Care Expense Claim**	**$**

REQUIRED DOCUMENTATION: All claims must include "complete" – "third-party" documentation. "Complete" documentation must include the: (1) patient's name; (2) service provider's name; (3) full date of service (including year); (4) description of service; (5) charge or patient portion for the service. If you have insurance, your carrier must process your claim prior to being reimbursed from your FSA. An Explanation of Benefits (EOB) from your insurance carrier is considered "complete" documentation. "Third-party" means provided to you by your service provider (e.g. doctor, pharmacy, day care, etc.) or insurance carrier.

CERTIFICATION: The undersigned participant in the Plan certifies that all services for which reimbursement is claimed by submission of this form were provided during a period while the undersigned was covered under the Plan with respect to such expenses and that the expenses have not been reimbursed and employee will not seek reimbursement from any other plan covering health benefits or from any other source. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim, which is provided by the undersigned, and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes, including federal and state income tax, on amounts paid from the Plan which relate to such expense.

***DO NOT USE THIS FORM IF YOU HAVE FILED YOUR CLAIM ONLINE**

______________________ ______________________

Employee's Signature Date

BASIC pacific ◆ P.O. Box 2170 ◆ Rocklin, CA 95677
Customer Service - (916) 303-7090 or (800) 574-5448

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Claim Form & Filing Instructions

When filing your claim, you must include copies of complete "third-party" documentation.

Your documentation must include:

(1) the service date (including the year);
(2) the name of the service provider;
(3) the patient's name;
(4) a description of the service provided; and,
(5) your total financial obligation for the service provided.

A statement from your service provider or an Explanation of Benefits (EOB) from your insurance carrier will usually include all of the required information.

The following documentation/receipts are NOT acceptable for reimbursement:

- Canceled Checks are never acceptable or needed. Please do not send them.
- Cash Register receipts for anything **other than over-the-counter** drugs and medicine UNLESS the patient name is indicated on the receipt.
- Credit Card receipts that do not contain the above (5) requirements.

NOTE: If your claim is returned because your documentation is incomplete or illegible, simply submit a new claim with complete and legible documentation.

You may send your claims to BASIC pacific using any of the following methods:

E-MAIL - E-mail claims to: **customerservice@basicpacific.com**

You must send us a scanned copy of your signed claim form and documentation as a single file to the e-mail address above in "PDF" format exclusively. No other format can be accepted. Claims that do not meet these requirements may be returned or delayed. Please be aware that e-mailing information over the Internet may not be secure.

FAX - Local - **(916) 303-7083** / Long Distance - **(800) 584-4591**

Please refrain from calling us immediately to confirm receipt of your fax. Faxed claims are not instantly available to our customer service representatives. In most cases, you will be able to view the status of your claims online within 2-business days at www.basicpacific.com.

MAIL - Mail to: **BASIC pacific Claims Processing, P.O. Box 2170, Rocklin, CA 95677**

Please DO NOT mail your claims "signature required" or it could delay your reimbursement up to a week or even more. We cannot be held responsible for mail that is lost or misrouted by the postal service. Mail received "postage due" will be returned.

If you register claims using the online portal, your claims are considered "received" only after BASIC pacific receives your supporting documentation.

Regardless of how you choose to send a claim, please send each claim ONCE ONLY. For example, please do not mail a claim that you have already faxed.

Keep a copy of your entire claim for your records.

You may make copies of this claim form for future use.

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