

The Mountain States Administrative Services
Quick Reference Guide



Filing your claims for reimbursement

Please keep in mind, expenses become eligible on the actual date the service occurred not the date of payment.
Be aware auto substantiation by stores or web sites might not be Flexible Spending Eligible.

Complete this section with 1 person, 1 place, 1 date of service per line. If you have more than the space allows use another claim form or make a spreadsheet.

Please note: if you have Medical, Dental, or Vision coverage with Mountain States your claim will first process through your benefit then the patient responsibility will pay from your flexible spending account.

Important

- Fill out the entire form
- Submit this form with the supporting documentation for all of the expenses you are claiming. Circle the date and the item on the receipt or EOB you are submitting.

FLEXIBLE SPENDING ACCOUNT CLAIM FORM					PLEASE PRINT OR TYPE ALL ITEMS				
NAME OF EMPLOYER				DATE OF CLAIM					
NAME OF EMPLOYEE FIRST		LAST		MI		ALTERNATE ID #			
ADDRESS: STREET		STATE		ZIP		CITY		DAYTIME TELEPHONE	
HEALTH CARE EXPENSE CLAIMS									
Person for Whom Expense Incurred and Relationship	Date of Service		Provider of Service		Expense Description	Amount of Claim			
Sally	01/01/10		Dr. Jones		Co-pay	50			
Joe	01/01/10		Drug Store		2 RX	20			
ATTACH COPY OF EACH RECEIPT - MARK RECEIPT WITH EMPLOYEE ALTERNATE ID NUMBER RETAIN ORIGINAL FOR YOUR RECORDS									
DEPENDENT CARE EXPENSE CLAIMS (example: Day Care Expenses)									
Name of Dependent	Age	Period Covered by Expenses From To		Name and Address of Provider of Service		SS# or EIN Of Provider	Amount of Claim		
Richard	4	01/01/10	01/31/10	Child Care		XXX-XX-XXXX	400		
ATTACH COPY OF EACH RECEIPT - MARK RECEIPT WITH EMPLOYEE ALTERNATE ID NUMBER RETAIN ORIGINAL FOR YOUR RECORDS									
STATEMENT OF CLAIM									
<ul style="list-style-type: none"> ♦ The undersigned participant in the Flexible Spending Account Plan (FSA Plan) certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was a participant in the FSA Plan. ♦ The undersigned participant certifies that the medical expenses submitted have not been reimbursed or are not reimbursable under any health plan coverage. ♦ The undersigned fully understands that he or she alone is responsible for the sufficiency, accuracy and veracity of all information relating to this claim. ♦ The undersigned agrees to provide additional verification of these expenses in the event of an audit by the Internal Revenue Service. ♦ The undersigned hereby requests reimbursement for the eligible expenses listed for the Participant or Participant's eligible dependents 									
SIGNATURE OF EMPLOYEE					DATE				
X _____					_____				

Read the Certificate section, sign, and date your claim form. Unsigned claims will not be processed.

How can I submit my claim form?

- Fax: 1 (520) 722-7127 **Please do not highlight your fax**
- Mail: Mountain States Administrative Services
7202 E Rosewood, Suite 200, Tucson, Arizona 85710-1351
- Email: FSA@mymzas.com