32520

CONEXIS human resourceful®

University of California Health FSA Claim Form

CONEXIS Account Number _____ ***or*** **Social Security Number** ___ - __ - ____

First Name _____ **Last Name** _____

E-mail Address (if not on file) _____

Category*	Patient First Name	Date of Service	Requested Amount
☐ Medical ☐ Dental ☐ Rx ☐ Vision ☐ Ortho ☐ OTC		/ /	$, .
☐ Medical ☐ Dental ☐ Rx ☐ Vision ☐ Ortho ☐ OTC		/ /	$, .
☐ Medical ☐ Dental ☐ Rx ☐ Vision ☐ Ortho ☐ OTC		/ /	$, .
☐ Medical ☐ Dental ☐ Rx ☐ Vision ☐ Ortho ☐ OTC		/ /	$, .
☐ Medical ☐ Dental ☐ Rx ☐ Vision ☐ Ortho ☐ OTC		/ /	$, .

Travel or mileage reimbursement: Miles must be itemized on a separate page listing date, miles traveled, and type of service. Check current IRS FSA rates per mile at mybenefits.CONEXIS.com. $, .

*Categories: Rx=Prescription OTC=Over the counter medication
Ortho=Orthodontic

Total Amount Requested $, .

Supporting Documentation

☐ I have attached documentation showing provider name, date of service, description of service, and patient responsibility amount.
☐ I have eligible expenses not covered by medical, dental or vision insurance and have attached itemized supporting documentation.

Employee Certification

- I certify the expenses listed for reimbursement are eligible healthcare expenses under the Internal Revenue Code and my employer's Flexible Benefits Plan ("Plan");
- I certify the services listed above have been received by me, my spouse, or my dependent on the dates indicated;
- I certify these expenses have not been submitted previously for reimbursement under the Plan and such items have not and will not be covered by any other plan or program of any employer or other person;
- I certify the services listed above were not purchased with my CONEXIS Benefit Card;
- I understand my employer does not accept responsibility for direct payment to any individuals other than the employee;
- I understand the expenses reimbursed may not be used to claim any federal income tax deduction or credit;
- I understand any unused contributions will be forfeited to my employer at the end of the plan year;
- I understand that I may be required to provide further details about some expenses, including a statement from a medical practitioner certifying the expense is for a specific medical condition;
- If my employer has adopted a grace period, I understand eligible expenses incurred and approved during a grace period will be paid first from any available amounts remaining in the plan year to which the grace period applies and then from the current plan year. If claims are submitted out of order, CONEXIS will provide a one-time reallocation at the end of the run-out period.
- In the event of an erroneous or excess reimbursement, I understand I am required to reimburse the Plan for the improperly paid amount. I further understand failure to repay the Plan could result in adverse income tax consequences.
- By providing my e-mail address, I authorize CONEXIS to send account information to me via e-mail.

Employee Signature _____ **Date** _____