uc-fsa.com
844-561-1338 · 866-451-3245
PO Box 2926 · Fargo, ND 58108-2926
forms@wexhealth.com

Claim Form

This form is used when you seek reimbursement for any eligible out-of-pocket expenses that have occurred. Your receipt(s) accompanying this form should include the following information: **(1) Date of service, (2) Description of service or item purchased, (3) Dollar amount (patient responsibility only) and (4) Name of provider.**

*Required Fields

*Participant Name (First, MI, Last)

*Social Security Number

*Employer Name (Do not abbreviate)

Employee ID

Claim Reimbursement Information

*Plan Type	*Service Dates (start and end dates - MM/DD/YYYY)	*Provider Name	Type of Service (i.e. Rx, Co-Pay, Dental)	*Out-of-Pocket Cost (i.e. Patient Responsibility)

Total: $

Claim Information – Dependent Care FSA only (no receipt needed when submitting a provider's signature)

*Service Dates (start and end dates - MM/DD/YYYY)	*Provider Name	*Provider's Signature	*Daycare Cost
-			$.

Participant Certification

To the best of my knowledge, the provided information is complete and accurate. I certify that the requests I am submitting are eligible expenses as defined by the IRS and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement from any other source. I understand that WEX, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. If submitting expenses for my Dependent Care Account, I have obtained or made reasonable efforts to obtain the provider's Tax ID (TIN) and I will include the TIN on IRS Form 2441, which I must attach to my federal income tax return. If submitting expenses for my Qualified Small Employer Health Reimbursement Arrangement (QSEHRA), I certify that I, or the individual for whom I am requesting reimbursement, continue to have Minimum Essential Coverage (MEC). I understand that if I fail to maintain MEC, any reimbursements made from my QSEHRA during the month in which I did not have MEC will become taxable. If submitting expenses for my Individual Coverage Health Reimbursement Arrangement (ICHRA), I certify that I, or the individual for whom I am requesting reimbursement, have (or had) individual health insurance coverage, Medicare Part A (Hospital Insurance) and B (Medical Insurance), or Medicare Part C (Medicare Advantage) during the month the expense was incurred. If there are any changes in the provided information, I understand it is my responsibility to notify WEX. By submitting this form I certify the above. Pursuant to the terms of the plan, benefit payments that are not timely claimed may be forfeited back to the plan. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit.

Submit Claims

Fax to:
866-451-3245
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No cover page required

Mail to:
WEX
PO Box 2926
Fargo, ND 58108-2926

Email to:
forms@wexhealth.com

File online:
benefitslogin.wexhealth.com/login
Claim form not required

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