Flexible Spending Account (FSA)
Claim Reimbursement Request Form

Submit a claim on your Chard Snyder online account or on the Chard Snyder Mobile App for quickest processing and reimbursement. Paper claims can be submitted by fax or mail, but expect longer processing times for these methods.

Company Information (PLEASE PRINT)

Company Name	Division (if applicable)

Participant Information (PLEASE PRINT)

Last Name		Primary Phone
First Name		Secondary Phone
SSN / (or Alternate Employee ID)	Date of Birth (mm/dd/yyyy)	Email Address (For Account Notifications)
Street Address		
City	State	Zip

If your claim includes expenses incurred by a spouse or eligible dependents, please provide the following information:

Dependent Name	Relationship	Date of Birth

Reimbursement Request (PLEASE PRINT)

Please indicate your eligible expenses below. **DO NOT include expenses reimbursed by any other source**.

HEALTH FSA

Attach copies of bills, receipts, Explanation of Benefits (EOBs) or other claim documentation. Documentation must include dates of service, description of service and the expense amount. Cancelled checks and/or credit card statements/receipts are NOT sufficient proof of your claim.

Date Range of Services	From through	**TOTAL Health FSA Reimbursement Request**
Description (Please list a brief description of services below – ie: Prescription, copay, contact solution, etc…)		$_____
IMPORTANT: If this is a Limited-Purpose FSA - Submit claims only for dental and/or vision expenses		**(REQUIRED)**

DEPENDENT CARE FSA

The following information is REQUIRED: Business name; dates of service and the expense amount; either a receipt/bill OR your provider's signature below. NOTE: Cancelled checks are acceptable for dependent care expenses only; credit card statements/receipts are NOT sufficient proof of your claim.

Date Range of Services	From through		**TOTAL Dependent Care Reimbursement Request**
Provider's Tax ID or SSN	**Provider's Business or Name**		$_____
Dependent Care Provider's Signature:		Date	**(REQUIRED)**

Claim Certification

To the best of my knowledge and belief, my statements on this form are complete and true. I certify that my family member or I have received the services described above on the dates indicated and that the expenses qualify as valid medical expenses under the plan. I certify that these expenses have not been reimbursed under any other plan, nor will I seek reimbursement for any of these expenses elsewhere. I understand that these expenses may not be used to claim any Federal income tax deduction or credit. **Any person who, with intent to defraud or knowing they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud or healthcare fraud under state and/or federal law.**

Participant Signature (Required)	Date

SEND THIS FORM TO CHARD SNYDER

Please submit this form to Chard Snyder by one of the two methods listed to the right

Fax: 888.887.9961 ***(Please DO NOT include a Fax Cover Page)***

Mail: P.O. Box 2905, Fargo, ND 58108-2905

Flexible Spending Account
Claim Reimbursement Instructions

1. **Complete all company and employee information** on the front page (please print/type). NOTE: Please include your e-mail address to receive an automatic e-mail notification whenever a claim is entered into our system and when a reimbursement is approved for you to receive payment
2. **Attach supporting documentation.** A copy of a receipt or EOB must accompany this request for each claim submitted for reimbursement. Each claim request must include the following information to be eligible for reimbursement:
   - ☑ Original date of service (not the date you paid the provider)
   - ☑ Description of the service performed (refer to list of eligible expenses to identify valid services)
   - ☑ Provider's name and address (If submitting receipts for dependent care expenses)
   - ☑ Amount charged to you (do not include amounts reimbursed or paid by another source)
3. **Health FSA Reimbursement Request:** Complete all required information *(ie: Total Reimbursement Request Amount)* and attach proof of expense as described above.
4. **Dependent Care FSA Reimbursement Request:** Complete all required information *(ie: Total Reimbursement Request Amount)* and attach proof of expense as described above. *Note: Canceled checks are acceptable as proof of payment*
5. **You MUST sign and date** the "Claim Certification" section on the front of this page
6. **Fax or Mail** this form and supporting documentation directly to Chard Snyder:
   - ☑ **Fax:** 888.887.9961 (***Please DO NOT include a Fax Cover Page***)
   - ☑ **Mail:** P.O. Box 2905, Fargo, ND 58108-2905
7. **If you have questions** please contact us:
   - ☑ **Call Participant Services:** 800.284.8412
   - ☑ **Visit our Website:** www.benefit-info.com/csn
8. **Important** Reminders**:**

   To ensure your claim is processed as soon as possible, and avoid delays:
   - ☑ Do NOT use a fax cover page when faxing
   - ☑ Do NOT highlight any part of your receipts, bills, etc.
   - ☑ Only mail copies of receipts, bills, etc. (Keep your originals)
   - ☑ Multiple receipts should be totaled on one claim form
   - ☑ Payments are issued after receipt and processing, subject to claim approval
   - ☑ Claims may not be paid across accounts (health from dependent care and vice versa)
   - ☑ Any items for which you are reimbursed cannot be claimed again as deductions or credits on your individual tax return at the end of the tax year
   - ☑ Dependent care claims may only be reimbursed for the amount you have in your account at the time of your claim. If your claim is for more than the balance in your account, the rest of your claim will be paid when more money is added
   - ☑ You may only be reimbursed for eligible expenses from the current plan year
     Note: Orthodontia expenses are reimbursed as designated by the provider
   - ☑ Payment will be made directly to you. Payments cannot be made to a provider or another person
   - ☑ Cancelled checks are NOT acceptable as proof of payment
   - ☑ Limited-Purpose FSAs may only reimburse claims for dental and/or vision expenses
   - ☑ If you request reimbursement by check and your approved payment is less than $25, we will wait to send reimbursement until we receive additional claims that make your total reimbursement amount at least $25. If we don't receive any additional claims, we will send your reimbursement at the end of the plan's runout period. There is no minimum amount required for reimbursement by direct deposit.

Sign up for direct deposit in your online account today! It's faster, more convenient, and more secure.