

Read detailed instructions on Page 2 prior to completing this form in order to prevent delays in processing.

Important Guidelines:

1. Total of the “Amount to be Reimbursed” must be at least \$25.
2. Faxed copies of the completed form are not acceptable.
3. List no more than 10 expenses per form; do not combine expenses or services, list one expense or service per line.
4. Staple appropriate Explanation of Benefits (EOBs), itemized bills(s) or receipt(s) to this form in the order listed.
5. Include only eligible expenses in the “Amount to be Reimbursed” column.
6. Do not attach multiple Reimbursement forms together and do not mix EOB’s and receipts with multiple forms.
7. Contact your department human resource professional to verify or change your home mailing address.

Section I: Faculty/Staff participant Information (please print)

Full Name	OSU Employee ID Number (Required)
Office/Daytime Phone Number	E-mail Address
Social Security Number (Optional)	

Section II: Health Care Expenses (List one expense or service per line)

	Date of Service MM/DD/YY	Type of Expense	Amount to be Reimbursed	Provider of Service or Supplies	Full Name of Person Receiving Service or Supplies
Sample	7/1/03	Dental	\$300.00	Dr. Tooth	Brutus Buckeye
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
Total must be at least \$25:					

Section III: Participant Certification

I have received, read and understand the material explaining the terms and conditions of The Ohio State University Flexible Benefits Plan. I understand that any person who, knowingly and with intent to defraud, files a claim containing any materially false information is guilty of fraud, which is subject to disciplinary action, up to and including termination of benefits and/or employment. I also certify, to the best of my knowledge, that the expenses included in this request are eligible health care expenses, have been incurred during the Plan Year, and have not been reimbursed by any other source. I understand expenses reimbursed from this account cannot also be claimed as a tax deduction on my Federal Tax return. I understand it is my responsibility to verify, with the IRS or my tax consultant, that this is an eligible expense, and that I assume all tax liability for this reimbursement. I certify that all information provided on this form is true and correct to the best of my knowledge.

Participant Signature (in ink)	Date
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Return completed form by NOON on Wednesday to: The Ohio State University, Office of Human Resources, Benefits Processing/FSA, 1590 N. High St., Suite 300, Columbus, OH 43201-2190.

Instructions for Health Care FSA Reimbursement

In order to process a Health Care FSA Request for Reimbursement, the form must be accompanied with the required documentation (described below), completed in its entirety, listing each expense separately—one per line, your original signature in ink, date signed, and total amount you are requesting (at least \$25).

Form Guidelines

- For each expense, provide the date of service, type of service, amount requested for reimbursement, provider name, and name of the person who received the service.
 - **Do not** combine expenses even if they occurred on the same date; each prescription, office visit, OTC expense, etc., must be listed individually on a separate line, 10 items per form.
- Tally the expenses in the “Amount to be reimbursed” column. Total expenses must be at least \$25.
- Incomplete forms, missing receipts/EOBs/ bills, or incomplete receipts/documentation will **delay** processing of your request.
- Claims submitted without the required documentation will be returned to you **unprocessed**.
- Guidelines for acceptable documentation are described in the table below.

Eligible Expenses

- Eligible and ineligible health care expenses are detailed via FSA Online at hr.osu.edu/benefits/healthflex.htm.
1. Eligible expenses must be for you, your spouse, or a child or person claimed as a dependent for tax purposes.
 2. The expenses must be incurred during the plan year in which you are enrolled.
 3. Health care expenses submitted for reimbursement must not be reimbursed or reimbursable by any insurance or other source.

Participant Records

You should retain copies of all paperwork submitted. Such information may be necessary for filing your federal tax return and/or undergoing an IRS audit of your personal tax return.

Availability of Participant Funds

- Requests totaling less than \$25 will be returned unprocessed.
- If a request is made for an eligible amount that exceeds your account balance, a check will be issued for the amount of the eligible request up to the annual pledge. There does not need to be sufficient funds deposited in the account at the time the check is processed.
- You may view your current account status, amount available for reimbursement, and year-to-date activity via FSA Online at: hr.osu.edu/benefits/healthflex.htm.

Reimbursement Checks

- Checks are normally processed each Friday and mailed to your home address.
- Request forms received by NOON on Wednesday are processed that week.
- Forms received after NOON will be processed the following week.

<p>Required for most Health Care Services:</p> <ul style="list-style-type: none"> • An Explanation of Benefits (EOB) from the insurance company, or • An itemized statement from the service provider that includes all of the following: <ol style="list-style-type: none"> 1. Name of service provider 2. Name of patient 3. Date of service 4. Details of the service or product 5. Cost of the service or product 	<p>Not acceptable for most Health Care Services:</p> <ul style="list-style-type: none"> • Cash register receipts • Balance forward statements • Cancelled checks • Credit card receipts or statements • Received-on-account statements • Estimates for service to be performed 				
<p>Required for an Office Visit Copay:</p> <ul style="list-style-type: none"> • A receipt or invoice that includes all of the following: <ol style="list-style-type: none"> 1. Name and address of service provider (must be pre-printed or stamped on the receipt or invoice) 2. Name of patient 3. Date of service 4. Wording indicating that this is an “office visit” or “copay” 5. Cost of the copay 	<p>Not acceptable for Office Visit Copays:</p> <ul style="list-style-type: none"> • Cash register receipts • Balance forward statements • Cancelled checks • Credit card receipts or statements • Received-on-account statements 				
<p>Required for Prescriptions:</p> <ul style="list-style-type: none"> • A copy of the itemized prescription label (often attached to the outside of the bag upon purchase); or invoice, if mail-order, which includes all of the following: <ol style="list-style-type: none"> 1. Name of pharmacy 2. Name of patient 3. Date prescription was filled 4. Name of the drug 5. Cost of the prescription (copay or coinsurance amount, or the full price of the drug if no insurance coverage) 	<p>Not acceptable for Prescriptions:</p> <ul style="list-style-type: none"> • Cash register receipts • Credit card receipts or statements <p>Note: If you did not retain a copy of your prescription label, contact your pharmacy.</p>				
<p>Required for Over-the-Counter (OTC) Medications:</p> <ul style="list-style-type: none"> • A <u>cash register receipt</u> that includes all of the following: <ol style="list-style-type: none"> 1. Name of the store or pharmacy 2. Date of purchase 3. Name of the item 4. Cost of the item (may include tax) 	<p>Note: The patient’s name is not required on the cash register receipt for OTC items. Certain OTC drugs require a medical practitioner’s note stating that the OTC drug is recommended to treat a specific medical condition and that the treatment is not a cosmetic procedure.</p>				
<p>Required for Orthodontia Services</p> <ul style="list-style-type: none"> • A copy of the Orthodontia Financial Agreement must be submitted each plan year. 					
<p>The following expenses or services require a medical practitioner’s written diagnosis and recommendation:</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 25%;">1. Massage Therapy</td> <td style="width: 25%;">2. Support Hose</td> <td style="width: 25%;">3. Viagra</td> <td style="width: 25%;">4. Weight Loss Program</td> </tr> </table>		1. Massage Therapy	2. Support Hose	3. Viagra	4. Weight Loss Program
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For More Information

If you have additional questions regarding reimbursement procedures, contact the Office of Human Resources Customer Service Center at service@hr.osu.edu, (614) 292-1050, or 1-800-678-6010.