



Reimbursement Claim Form

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

Important Guidelines:

1. This form should be used to submit reimbursement requests for The Ohio State University's Health Care Flexible Spending Account (HC FSA), Health Reimbursement Account (HRA) and/or Dependent Care Flexible Spending Account (DC FSA).
2. List no more than 10 expenses per form; do not combine expenses or services; list one expense or service per line.
3. Provide itemized documentation of each expense.
4. Include only eligible expenses in the "Amount to Be Reimbursed" column.
5. Write legibly and do not highlight amount on your receipt.
6. Keep copies of this Reimbursement Claim Form and all receipts.

SECTION 1: EMPLOYEE INFORMATION

Employee's Full Name: First _____ M.I. _____ Last _____ OSU Employee ID# (required) _____

Daytime Phone Number _____ Email Address _____

SECTION 2: EXPENSES (list one expense or service per line)

In the "Benefit Type" column, use HEALTH for a health care expense or DCFSA for a dependent care expense.

	Benefit Type	Start Date of Service MM/DD/YY	End Date of Service MM/DD/YY	Type of Expense	Amount to Be Reimbursed	Service Provider	Full Name of Person Receiving Service	Relationship to Employee
Ex.	HEALTH	01/02/2017	01/02/2017	Dental	\$300.00	Dr. Tooth	Brutus Buckeye	Self
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

In a situation where an incurred medical expense could be reimbursed from either the HC FSA or the HRA, eligible expenses will first be paid from the HC FSA. All HC FSA funds must be exhausted before HRA funds are used. Claims will be applied to the earliest eligible plan year.

SECTION 3: PARTICIPANT CERTIFICATION

I authorize the above expenses to be reimbursed from my HC FSA, HRA and/or DC FSA, as applicable. To the best of my knowledge, my statements in this Reimbursement Claim Form are true and complete. I certify that, with respect to claimed health care expenses, such expenses qualify as "eligible health care expenses" as defined in the University's Flexible Benefits Plan or the HRA provisions of the Faculty and Staff Health Plans Specific Plan Details Document, as applicable, and, with respect to claimed dependent care expenses, such expenses qualify as "qualifying employment-related expenses" under the Flexible Benefits Plan. In addition, I certify that the expenses described above were incurred on the dates indicated above and have not been and will not be reimbursed by or from any other source. I understand that expenses for which I am reimbursed may not be used to claim any federal income tax deduction or credit. I also understand that HC FSA funds must be exhausted before any HRA funds may be used. In addition, I understand that I may be asked to provide further details about some expenses.

Participant Signature (in ink) _____

Date _____

Completed Reimbursement Claim Form(s) should be sent to TASC via:
 Fax: **1-877-231-1287** or Mail: TASC, PO Box 7511, Madison, WI 53707-7511

INSTRUCTIONS FOR COMPLETING FORM

- Fill out the Reimbursement Claim Form completely, including signature and date, and fax or mail to TASC at the address listed above.
- If sending multiple Reimbursement Claim Forms, each Reimbursement Claim Form must have receipts placed directly behind the applicable Reimbursement Claim Form. If one receipt covers expenses on multiple Reimbursement Claim Forms, make a copy of the receipt and submit with each applicable Reimbursement Claim Form.
- Copies of cancelled checks or credit card receipts cannot substitute for an itemized bill. Statements with a "Balance Forward" or "Previous Balance" cannot be processed. Incomplete and unsigned Forms will be denied and returned.
- TASC processes reimbursements daily. Reimbursement payments are initiated within 48 to 72 hours of receipt of a complete and accurate reimbursement request.

HC FSA or HRA Reimbursement Claims Filing Instructions

1. Eligible and ineligible expenses are detailed at go.osu.edu/fsa-hra-expenses.
2. When completing the Reimbursement Claim Form, enter each different expense on a separate line, identifying the benefit type, start date and end date of service, type of expense, amount to be reimbursed, service provider, individual receiving services and relationship to employee. Dates of Service always represent the date services are incurred or rendered. Future dated services are not eligible.
3. Attach copies of the appropriate Explanation of Benefits (EOBs), itemized bill(s) or receipts (retain originals for your records) to this form in the order listed.
4. Attach all required written diagnoses, physicians' recommendations and OTC prescriptions to the Reimbursement Claim Form.
5. Remember to sign and date each Reimbursement Claim Form submitted to TASC.
6. You are expected to maintain a copy of supporting records and documents to validate the expense type and amount.
7. TASC may require additional information or documentation prior to processing a Reimbursement Claim Form.

DC FSA Reimbursement Claims Filing Instructions

1. Eligible and ineligible expenses are detailed at [IRS Publication 503, Child and Dependent Care Expenses](#).
2. When completing the Reimbursement Claim Form, enter each different expense on a separate line, identifying the benefit type, start date and end date of service, type of expense, amount to be reimbursed, service provider, individual receiving services and relationship to employee. Dates of Service always represent the date services are incurred or rendered. Future dated services are not eligible.
3. Attach copies of the itemized bill or receipt with the information set forth below. Evidence that you have paid a dependent care expense is not required in order for it to be reimbursed. The expense needs only to have incurred. The provider may be paid after the claim has been reimbursed, if such arrangements are acceptable to the provider.

Name of dependent(s) receiving service

Age of dependent

Beginning and ending service dates, including month, day and year

Total Charge

Provider's Name and Address

Provider's taxpayer ID number. If provider is an individual, his/her social security number must be supplied

4. If an eligible request is made for an amount that exceeds your account balance, a check will be issued for your account balance. The difference will be paid when your next payroll contribution is deposited. You may view your current account online at eprofile.osu.edu.
5. Remember to sign and date each Reimbursement Claim Form submitted to TASC.
6. You are expected to maintain a copy of supporting records and documents to validate the expense type and amount.
7. TASC may require additional information or documentation prior to processing a Reimbursement Claim Form.

For more information:

View your current account balance and year-to-date activity, and file online reimbursement claim forms via eprofile.osu.edu.

If you have questions regarding reimbursement procedures or your accounts, contact TASC Customer Service at **1-855-FLEX-OSU** (855-353-9678).