Health FSA Reimbursement Form

page _____ of _____

Fax to: 877-488-6454 Please do not use a cover sheet when faxing. For faster service fax this entire sheet along with the appropriate documentation.

Employee Name: Last | First | Middle Initial | Social Security Number - -

Home Address ☐ check if new | Number/Street | Apt# | City | ST | Zip | Daytime Phone Number ( ) -

Company Name: **Loyola University New Orleans** | Client Code: **plb967**

By submitting this form, I attest and agree to the following: To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year (or period of coverage) for myself, my spouse and/or my dependent(s). These expenses have not previously been reimbursed under this FSA plan, nor will they be reimbursed under any other benefit plan or claimed as an income tax deduction. If there is a discrepancy between the total amount of expenses claimed on this form and the total amount of eligible expenses on the accompanying documentation, I understand I will be reimbursed for the total amount of eligible expenses on the accompanying documentation unless I provide written instruction to reimburse a lesser amount.

Employee Signature X _____ **Date** _____

Step 1. Complete this section of the reimbursement form for eligible expenses incurred during your FSA plan year while you were a participant. Health care expenses must be processed by your insurance company first, they will provide you with an Explanation of Benefits (EOB). An expense is incurred when the service is provided, not when you are billed or pay for the service.

For Health Care expenses:

- You must complete the boxes in this section for each expense in order for your claim to be processed properly
- Use additional page(s) if needed
- An Explanation of Benefits (EOB) from your insurance company or an itemized bill(receipt) is required to process this claim
- Your receipts must contain the following:
  - Date of Service
  - Provider of service
  - Type of Service
  - Amount of service
- Rx number or drug name must be stated on all receipts
- Copies of receipts for each expense claimed must be attached to the form

Date of Service	Provider	RX number, Drug Name or Type of Service	Amount of Service
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$

Subtotal health care expenses $ _____

Step 2. Fax to 877-488-6454. Return this completed reimbursement form and appropriate documentation. Requests received via fax will be processed the later of two business days after receipt or prior to your next scheduled reimbursement date. If you prefer, mail to: Ceridian FSA Services, P.O. Box 534134, St. Petersburg, FL 33747. Claims received via mail may require one additional day for processing. Please keep original receipts as required by the IRS.

Visit www.ceridian-benefits.com 24 hours a day to obtain account information and additional reimbursement forms. For additional information, please call our customer service center at 877-799-8820 Monday through Friday, during the hours of 8 a.m. to 8 p.m. Eastern Time.

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