

Flexible Spending Account (FSA) Claim Form



Instructions For Quick Claim Processing:

- Fully complete & sign this claim form
- Attach copies of supporting EOB, receipts, vouchers, bills, etc.
- All receipts must include a date, description, and amount of the service
- Please list one expense per line
- Please print in dark blue or black ink when using this form
- Please allow 2 business days for claims to be processed

For Account Balance:
Go to my.nbsbenefits.com
or call (855) 399-3035

1 Personal Information

Employee Name _____	Company Name _____
Street Address, City, State, Zip _____	<input type="checkbox"/> No <input type="checkbox"/> Yes Address Change?
Phone Number _____	Social Security Number _____

2 Dependent Care Expenses (Dates of Service are required in order to process claim)

	Date of Service		Service Provider Tax ID# or SS#	Dependent's Name	Age	Amount
	Start Date	End Date				
1	_____	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____	_____
4	_____	_____	_____	_____	_____	_____
Total Dependent Care Expenses						_____

3 Health Care Expenses

	Date of Service			Medical	Rx	Dental	Vision	Hospital	Ortho dontia	Other Services: Please Specify	Person Receiving Service	Amount
	MM	DD	YY									
1	___	___	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
2	___	___	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
3	___	___	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
4	___	___	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
5	___	___	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
6	___	___	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
7	___	___	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
8	___	___	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
9	___	___	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Total Health Care Expenses												_____

4 Employee Signature

I, the undersigned, attest that to the best of my knowledge these statements are complete and true. I authorize the release of any medical information to my spouse. I certify these expenses are for valid services provided on the dates indicated and will not be reimbursed or claimed under any other Plan or claimed as a tax deduction.

Employee Signature _____	Date _____
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Please fax, mail, or email your claim form and receipts to the following:
Mail: National Benefit Services, LLC, P.O. Box 219393, Kansas City, MO 64121-9393
Email: service@nbsbenefits.com (PDF, TIFF, or JPG files only)