BASIC FLEX

How to Submit
Secure Upload: Via Employee Portal
Fax: 269-327-0716
Mail: BASIC•9246 Portage Industrial Dr. •Portage, MI 49024

FSA/DCA Card Claim Form

Participant Information

To Update your information, log on to your account at www.basiconline.com/account_access

Employer: **Company**

Name: Farhad Khalafi Social Security #: 123-45-6789

Eligible Medical & Dependent Care Expenses

Medical Expenses:
- Documentation for each request must show
  - Date(s) of service
  - Description of service provided
  - Charge for the service
  - Provider's name and address.

Over-the-Counter Items:
- Any items considered to be a "medicine", i.e. Tylenol®, cold medicine, Ibuprofen etc., will require a Letter of Medical Necessity (LMN) from your medical provider. LMN is good for one year from date of issue.

Dual Purpose Procedures:
Some medical treatments such as massage therapy and gym memberships will also require a Letter of Medical Necessity.

Dependent Care (Day Care) Expenses:
- Documentation for each request must show
  - Date(s) of service
  - Name of provider/day care center
  - Charge(s)/Amount for care
  - Provider's name and address

Eligible Expenses:
- Child(ren) must be under the age of 13
- Care for child(ren) while you and your spouse are working
- Care for a dependent that is physically or mental not able to care for oneself.

Expenses Not Eligible:
- Care for Child(ren) over the age of 13
- Overnight camps
- Care for child(ren) while you are not working (vacation, leave of absence, day off, etc)

Signature of Day Care Provider: _____

Your provider may sign this form on the line above or provide a receipt for services.

Itemized Medical & Dependent Care Expenses

Benefit Card used for this expense [please check yes or no]	**Medical or Day Care Expense** [please check expense type]	**Date(s) of Service** [provide the date or date range which service(s) were provided]	**Service Provider** [The name of the provider who provided the service]	**Amount** [Enter the reimbursement amount requested]
☒ Yes ☐ No	☒ Medical ☐ Day Care	11/23/2345	Dr. Smith	$ 1,234.56
☐ Yes ☒ No	☐ Medical ☒ Day Care			$
☒ Yes ☐ No	☐ Medical ☐ Day Care			$
☐ Yes ☒ No	☒ Medical ☒ Day Care			$
● Yes ☐ No	☒ Medical ☐ Day Care			$

I certify that I have not already been paid for these expenses from my Medical/Dependent Care Plan or any other source. I have submitted the above information in good faith and it is correct to the best of my knowledge. I understand that reimbursement is not a guarantee. The service for which I am requesting reimbursement must be incurred during my period of participation. Services incurred after participation ends are not eligible for reimbursement even if there was a balance remaining in my account.

Signature: _____ Date: 1/12/2016