



Horizon Blue Cross Blue Shield of New Jersey

Horizon BCBSNJ FSA  
P.O. Box 829  
Newark, NJ 07101-0829  
Phone: (877) 663-7258  
Fax 973-274-2233  
www.HorizonBlue.com/Merckfsa

## CLAIM FOR REIMBURSEMENT

Company Name \_\_\_\_\_ ID # \_\_\_\_\_

Your Name \_\_\_\_\_ Phone # \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

☐ Check here if new address

### DEPENDENT CARE (DAYCARE) FSA CLAIMS

Name of Dependent(s)	Period Covered		Name and Address of Provider of Service	Taxpayer ID or Member ID	Amount Incurred
	From	To			

### HEALTH CARE FSA EXPENSE CLAIMS

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount	*No Ins. Coverage (Initial)
Total Medical Care Expenses Claimed					

**Read Carefully:** The undersigned participant in the plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the company Flexible Spending Account Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that (s)he alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the plan which relate to such expense.

\*No insurance coverage for expense - please initial.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

***READ CAREFULLY***  
**CLAIM FILING INSTRUCTIONS**

**Who files a claim form?**

- Only employees participating in the company Flexible Spending Account Plan can file a reimbursement claim form.
- Employees can file a claim for during the plan year and for a certain period after the plan year as described in the Summary Plan Description.
- Terminated employees can file a claim form for a certain period after the date of termination if allowed by the plan.  
**Please see your Summary Plan Description.**

**Which expenses can I claim?**

- You can claim only expenses incurred during the plan year for reimbursement. Each year is treated separately and the year of claim is the year the expense was actually incurred by the participant. You must send separate claim forms for each year.
- Terminated employees can request reimbursement for expenses incurred during the time period for which contributions were received. **Please see your Summary Plan Description.**
- Allowable expenses are the same as those allowed for tax purposes. **See the summary below.**

**Qualifying dependent care expenses**

- Expenses paid to a dependent day care center or care provider.
- Expenses paid for the care of a dependent under age 13.
- Expenses paid for care of other dependent(s) who are physically or mentally incapable of caring for themselves.

**Qualifying unreimbursed medical expenses**

- You can only claim expenses not reimbursed by insurance, including:

Ambulance hire	Blood donor	Hospital bills	Oral surgery	Rental of	Telephone for deaf
Artificial limbs/teeth	Chiropractor	LASIK eye surgery	Osteopath	medical/healing	Television set
Automobile modifications	Christian Science	Lip reading lessons	Oxygen equipment	equipment	modifications to
(hand controls/special	practitioners	for the deaf	Pediatrician	Retirement home	receive closed
equipment/mechanical	Clinic	Medical	Physician	fees, portion	captions
lifts)	Dentist (excluding	Midwife	Physiotherapist	allocable to	Therapy treatments
Braille books/magazines	cosmetic services,	Nurse	Podiatrist	medical care	Transportation
Crutches	i.e., teeth whitening)	Obstetrician	Practical nurse	Seeing eye dog	expense relative to
Elastic hose, medically	Diagnosis	Obstetrical expense	Prescription drugs and	Sex therapist	illness
prescribed	Diathermy	Oculist	medical supplies	Special education	X-rays
Eyeglasses/contact	Exam, physical	Operations/related	excluding cosmetic Rx	Specialist	Wheelchair
lenses/solutions	Gynecologist	treatments	Psychiatrist	Supportive/corrective	
Eye exam	Halfway house	Ophthalmologist	Psychoanalyst	devices (including	
Fees	residency	Optician	Psychologist	special mattress/	
Acupuncture	Healing services	Optometrist	Psychopathist	board for arthritis)	
Anesthetist	Hearing devices			Surgeon	

**Completing the claim form**

- Complete **all** information on the claim form for each amount claimed for reimbursement.
- Make sure the claim does not include items for more than one plan year. Use different claim forms for different years.
- **You must sign and date the claim form.**
- Attach copies of bills, invoices or other written statements from a third party that support each reimbursement request and mail or fax to:

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