Ensure the most current form is submitted. Refer to EMACS Forms/Procedures website.

MEDICAL EXPENSE REIMBURSEMENT (FSA) PLAN REIMBURSEMENT CLAIM FORM

Select group that includes your bargaining unit:

☐ **General Group 1:** General (SBPEA), Professional, Safety, Safety Management and Supervisory, Specialized Peace Officer-Supervisory, Specialized Peace Officer, Non-Represented, Water and Sanitation, Specialized Fire Services, Firefighters, Local 935, General Fire Support, Special Districts Non-Represented

☐ **General Group 2:** Nurses, Probation, Emergency Services

☐ **Exempt Group**: Exempt, Exempt- Special Districts/County Fire, LAFCO, Elected Officials

Must print in Black or Blue ink ONLY

Employee ID	Last Name, First Name	Email Address
Mailing Address, City, State, Zip Code		**Telephone**

Reimbursement of Claims

Under the FSA Plan, reimbursement for claimed expenses may be obtained by meeting Internal Revenue Code (IRC) Section 213 requirements and must be incurred for yourself, your spouse and/or qualified dependent(s), as defined by IRC Section 152 and the FSA Plan Documents. In addition, the expense(s) incurred for services rendered must be claimed during the plan year to which they apply. **In lieu of completing this paper claim form, you may submit your claim and supporting documentation online through the** Participant Portal**, or use your Benefit Card.** ***Note: Do not file a claim form for expenses which were paid for with your benefit card and/or previously submitted through the Participant Portal.***

To request reimbursement for your eligible medical expenses, attach a copy of supporting documentation from the provider, vendor, or merchant. In addition, the following fields on the claim form must be completed:

- Date of Service: date should be itemized per individual and claimed expense
- Provider
- Expense Category (e.g., dental, drugs & medicines, medical expenses, etc.)
- Type of Service (e.g., dental copay, prescription medication copay/cost, chiropractor, etc.)
- Recipient (name of person receiving medical service)
- Claim Amount

In addition to the above, supporting documentation from the provider, vendor, or merchant (e.g., receipt, statement, or bill) must include the following:

- Description of service or product rendered
- Proof of amount you paid for expense
- Amount paid by other party (e.g., insurance) for expense

Mileage

You can include medical expenses for travel to and from your medical care provider with your FSA reimbursement claim form. The standard mileage rate will apply and vary per Internal Revenue Service regulation each year. You may use the Mileage Expense Worksheet to claim the number of total miles traveled, date(s) of service, the provider's information, and category. You also need to include a print out of an online map source (e.g., MapQuest) that includes the starting and ending destination points and total miles traveled. Refer to the example on page 2 to complete the fields required on the mileage expense form. **Note: If you are claiming mileage for medical care for which you did not incur an expense (e.g. Office Visit with no copay amount) or are claiming mileage for expenses you received reimbursement for earlier in the plan year, include documentation that supports your mileage was incurred for medical purposes (e.g. proof of Office Visit).**

Submit your completed FSA Claim Form by email, postal or interoffice mail, or fax to:

San Bernardino County - Human Resources
Employee Benefits and Services Divison
157 W. Fifth St., First Floor
San Bernardino, CA 92415-0440
email: hrfsadcap@hr.sbcounty.gov
IOM: HR-EBSD - 0440
Fax: (909) 387-5566

DISTRIBUTION: Original - EBSD-HR

HR EBSD Office Use Only

Reviewed By (Employee ID)	Date	Keyed By (Employee ID)	Date	Audited By (Employee ID)	Date

REIMBURSEMENT CLAIM FORM

Instructions: Refer to the Reimbursement of Claims section on page 1. See example on line one (1) below.

Claim #	Date of Service	Provider Name	Category (e.g., Dental, Drugs & Medicines, Medical Expenses, etc.)	Type of Service (e.g., Dental Copay, Prescription Copay/Cost, Chiropractor, etc.)	Recipient	Claim Amount	Approve/ Deny (HR use only)
1.	12/16/2013	Kaiser Permanente	Medical	Medical copay	Jane Doe	$10.00	☒ Approve ☐ Deny
2.							☐ Approve ☐ Deny
3.							☐ Approve ☐ Deny
4.							☐ Approve ☐ Deny
5.							☐ Approve ☐ Deny
6.							☐ Approve ☐ Deny
7.							☐ Approve ☐ Deny
8.							☐ Approve ☐ Deny
9.							☐ Approve ☐ Deny
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12.							☐ Approve ☐ Deny
13.							☐ Approve ☐ Deny
14.							☐ Approve ☐ Deny
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17.							☐ Approve ☐ Deny
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21.							☐ Approve ☐ Deny
22.							☐ Approve ☐ Deny
23.							☐ Approve ☐ Deny
24.							☐ Approve ☐ Deny
25.							☐ Approve ☐ Deny
26.							☐ Approve ☐ Deny
					Total Claim Amount:		

I acknowledge the statements in this claim form to be true and correct. I certify that if any dependent(s) are listed above they are my dependents as defined by Internal Revenue Code Section 152 and the FSA Plan Document. I agree to notify my employer if i have reason to believe that any expense(s) for which I have obtained reimbursement, is not a qualifying expense. I agree to provide any additional information if necessary to complete the process of my reimbursement claim form. I certify that the Over-the-Counter (OTC) drugs and/or products are for an existing illness or injury and are not for general health or cosmetic purposes (hair growth, weight loss, wrinkles, etc.). I acknowledge, I have not been reimbursed previously under the Medical Expense Reimbursement (FSA) Plan or any other health plan, nor do I expect any of the expenses to be reimbursable elsewhere. I understand that the expenses may not be used to claim any Federal income tax deduction of credit.

Employee (Print & Sign)	Employee ID	Date

MILEAGE EXPENSE WORKSHEET

Instructions: Use this form to claim mileage. Attach a copy of an online map source (e.g., MapQuest) for any mileage claimed. See example on line one (1).

Claim #	Date of Service	Provider Name Address, City, State, Zip Code	Category (e.g., Dental, Drugs & Medicines, Medical Expenses, etc.)	Type of Service (e.g., Dental Copay, Prescription Medication Copay/Cost, Chiropractor, etc.)	Total Miles Traveled	Claim Amount	Approve/ Deny (HR use only)
1.	**12/16/2013**	**Kaiser, 1234 Florida St., San Bernardino, CA 92415**	**Medical**	**Medical copay**	**36.6**	**$8.94**	☒ Approve ☐ Deny
2.							☐ Approve ☐ Deny
3.							☐ Approve ☐ Deny
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25.							☐ Approve ☐ Deny
26.							☐ Approve ☐ Deny
27.							☐ Approve ☐ Deny
					Total Claim Amount:		

I certify that the statements above are true and correct. I understand that the mileage standard rate may vary each year per IRS regulations. Therefore, I allow the County to make any adjustments necessary to my mileage worksheet as long as it is in accordance with IRS regulations and the FSA Plan Document. I understand that I may be asked to provide additional information for any mileage claimed. I acknowledge that any mileage claimed for reimbursement may not be used for any federal income tax deduction or credit.

Employee (Print & Sign)	Date