

FLEXIBLE SPENDING ACCOUNT - CLAIM FORM

This claim form is for requesting "reimbursement" from your Flexible Spending Account for medical care or dependent care expenses. In order to be reimbursed, attach all appropriate documentation, such as, Explanation of Benefits from insurer, proof of co-payment from healthcare provider, prescription receipt or receipts for other expenses not covered by your insurance.

No reimbursement will be given unless this form is signed where indicated.

Deliver or Mail Form to:

Augusta State University
Business Office
Fanning Hall, 1st Floor
2500 Walton Way
Augusta, GA 30904

Medical Care

Dependent Care

Medical and Dependent claims must be filed on separate forms.

Please use additional forms as needed.

If you have questions, please call the Business Office at 706 737-1767.

EMPLOYEE NAME	EMPLOYEE ID NUMBER
HOME ADDRESS	
CITY, STATE, ZIP CODE	TELEPHONE

IF CLAIM IS FOR MEDICAL CARE, COMPLETE THE FOLLOWING SECTION.

1	DEPENDENT NAME	AGE	FULL-TIME STUDENT? YES/NO <input type="checkbox"/>	RELATIONSHIP
2	DEPENDENT NAME	AGE	FULL-TIME STUDENT? YES/NO <input type="checkbox"/>	RELATIONSHIP
3	DEPENDENT NAME	AGE	FULL-TIME STUDENT? YES/NO <input type="checkbox"/>	RELATIONSHIP

IF CLAIM IS FOR DEPENDENT CARE, COMPLETE THE FOLLOWING SECTION.

1	PROVIDER OF SERVICE	ADDRESS
	AMOUNT OF CHARGE \$	PERIOD OF SERVICE COVERED IN THIS CLAIM
2	PROVIDER OF SERVICE	ADDRESS
	AMOUNT OF CHARGE \$	PERIOD OF SERVICE COVERED IN THIS CLAIM
3	PROVIDER OF SERVICE	ADDRESS
	AMOUNT OF CHARGE \$	PERIOD OF SERVICE COVERED IN THIS CLAIM

COMPLETE THIS SECTION FOR ALL REIMBURSEMENT CLAIMS

CALENDAR YEAR TO WHICH PAYMENTS APPLY	TOTAL AMOUNT REQUESTED FOR THIS REIMBURSEMENT \$
DATE	SIGNATURE OF EMPLOYEE

I understand that I am responsible for any tax reporting or other legal requirements with respect to reimbursed expenses. I also understand that medical/dependent care expenses that are reimbursed under the Health/Dependent Care Flexible Spending Account may not be claimed as expenses against the Federal income tax credit for medical/dependent care expenses.

I authorize the release of medical/dependent information to process this claim. I attest that the expenses for which I am asking reimbursement have actually been paid by me.

For Business Office Use Only
Reviewed By

Date: _____

Voucher #: _____