Health Care Flexible Spending Account
Claim Form

1. Before submitting a claim for reimbursement from your Health Care Flexible Spending Account, you must first file for benefits covered under any other medical, dental, HMO plans or reimbursement accounts.*
2. Complete Section I and II. You will need to attach an **original itemized statement and/or receipt** for each item you would like reimbursed. If you have received coverage under another plan please submit your Explanation of Benefits (EOB) with your claim form.
3. Submit completed original claim form and original itemized statement/receipt to the address shown at right.

Mail To: Health Care FSA Claims
MMSI
4001 41st Street, NW
Rochester, MN 55901-8901

Intraclinic Mailing Address:
Health Care FSA Claims
Mayo Support Center North – SN 3
MMSI

Phone: 6-6360 (on Rochester campus)
(77)6-6360 (on other Mayo campus)
507-266-6360 (local)
1-866-517-1615 (toll Free)
1-800-407-2442 (TDD)

SECTION I

Last Name (Account Holder)		First Name / Middle Initial	Mayo Employee ID Number *(Six Digits)*	
Work Phone	Home Phone	Last 4 Digits of SSN	Birth Date *(Month DD, YYYY)*	
Address - *Street*		City	State	ZIP Code

SECTION II

Service Date *(Month DD, YYYY)*	Description of Eligible Expenses	Name/Relationship of Individual Receiving Care	Total Amount of Bills	Amount Paid By Any Other Plans	Amount to be Reimbursed
				Total	

SECTION III – Account Holder Certification

I authorize the expenses above to be reimbursed through my Health Care Flexible Spending Account. I certify that, to the best of my knowledge, the expenses I am submitting meet the requirements of qualified health care expenses as covered by this plan as explained on the back of this form. I further certify that these expenses are not reimbursable under any other plan, including a plan of another employer that covers me, my spouse, or another member of my family.

Account Holder Signature ______________________________ Date *(Month DD, YYYY)* ____________________

Processing Guideline: All completed claim forms received by 5:00 p.m. on any given payday will be processed by the following payday. Your reimbursement will be included in your statement of earnings listed as: 598 HLTH REIMB.

* The Mayo Reimbursement Account or Dental Assistance Plan must be exhausted before you use your pretax Health Care Flexible Spending Account for eligible dental and vision expenses.

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GENERAL INFORMATION

Eligible health care expenses for which you submit a claim must be incurred while you are a participant, in the plan calendar year, and must not be reimbursed by any insurance, other reimbursement accounts, or an HMO. You may not claim a medical expense deduction on your income tax return for which you were reimbursed from your Health Care Flexible Spending Account. Total expenses reimbursed from the Plan and any other similar plan sponsored by another employer may not exceed a family maximum of $3000 in one year. You may be reimbursed for healthcare expenses incurred by you on behalf of yourself, your spouse, or your dependents. Your "dependents" are persons who qualify as dependents on your federal tax return. The term "dependent" does not include any individual who is not a US citizen or national, unless the individual is a resident of the US or a country contiguous to the United States.

Examples of **eligible** healthcare expenses are:

- Acupuncture treatment
- Braille books
- Christian Science Practitioner charges
- Chiropractic charges
- Contact lenses* (includes materials and equipment needed to maintain lenses: cleaner, saline, etc.)
- Convalescent home medical treatment
- Dental treatment and deductibles*
- Eye examinations, prescription eyeglasses*
- Hearing aids and batteries
- Hospital and physician charges
- Kidney donor's expenses
- Laser eye surgery for vision correction (LASIK)
- Medical care plan deductibles and copays
- Nursing charges for medical services
- Prescription drugs and deductibles
- Over-the-counter pharmaceuticals (antacids, allergy medicines, pain relievers, cold medicines, acne medications, smoking cessation patches/gum, hydrocortisone creams)
- Orthodontia (see special requirements on claim filing)
- Special costs for physically and mentally handicapped children

Examples of **ineligible** healthcare expenses are:

- Cosmetic surgery
- Clip-on or non-prescription sunglasses
- Custodial care
- Dental services for bleaching of teeth
- Electrolysis
- Fitness programs and/or health club dues
- Hair transplant
- Massage therapy
- Over-the-counter drugs (dietary supplements, toiletries, cosmetics, sundry items, etc.)
- Prescription drugs for cosmetic purposes (Retin-A, Rogaine, Propecia, etc.)

Special Requirements for Claim Filing for Orthodontia:

If you are using this account for orthodontia, an itemized statement and/or copy of your contract outlining the treatment plan must accompany your claim for each year you participate. To determine the amount you can pretax, you need the following information:

1. Your out-of-pocket expense after insurance.
2. Number of months in the treatment plan.
3. Number of treatment plan months in the calendar year you are participating.

To determine an eligible amount for pretax, divide number 1 by number 2. This result is then multiplied by number 3. The result is the amount you can pretax in the calendar year in which you are participating.

Claim Filing Deadline:

March 31 of the following year is the deadline to submit claims for expenses incurred in the calendar year in which pretax contributions were made. Any funds remaining in your Health-Care Flexible Spending Account after the deadline are forfeited.

* Eligible expenses must first be filed for benefits under any other medical, dental, HMO plans or reimbursement accounts. The Mayo Reimbursement Account or Dental Assistance Plan must be exhausted before you use your pretax Health Care Flexible Spending Account for eligible dental and vision expenses.