



# Health Care Spending Account Reimbursement Form

*Disbursements will be made on alternating Wednesdays. This form must be completely filled out and received by Zenith Administrators no later than the Friday prior to the disbursement in order to be included.*

**SECTION ONE: PARTICIPANT INFORMATION**

Last Name:	First Name:	M.I.	Home Phone Number:
Mailing Address:			Work Phone Number:
City:	State:	Zip Code:	Participant's Social Security Number: ____-____-____
Is this a new address for you? <input type="checkbox"/> YES <input type="checkbox"/> NO			

**SECTION TWO: HEALTH CARE SPENDING ACCOUNT REIMBURSEMENT INFORMATION**

In order to receive reimbursement, please complete the following in full, and attach a copy of the Explanation of Benefits (EOB) issued by your insurance company or claim administrator. The EOB shows the uncovered health care expenses and the reason why the claim was not paid or not paid in full. You must provide an EOB for all medical and dental expenses. For vision claims, provide a copy of your provider's invoice showing the patient's name, date of service, type of service, and the amount paid by insurance. For prescription drug claims, you must provide a copy of the prescription receipt showing the patient's name, date of service, type of prescription, and co-payment amount. For over-the-counter drug claims you must provide proof of purchase including name of the medication, the price and the date of purchase.

Patient's Name	Age	Relationship to Participant	Dates of Service	Type of Service (Med/Den/Vis/Rx)	Amount of Requested Reimbursement*

\*You must calculate the amount you wish to claim from your health care spending account. We cannot process your reimbursement request without this information. Total: \_\_\_\_\_

**SECTION THREE: PARTICIPANT CERTIFICATION AND SIGNATURE**

I request reimbursement for the eligible expenses listed above. I certify that the above information is correct and that I have not received reimbursement for these expenses from this spending account, and have not and will not receive reimbursement for these expenses from any other plan. I understand that expenses reimbursed under the Health Care Spending Account cannot be used to claim a deduction or tax credit on my personal income tax.

\_\_\_\_\_ Date  
Participant's Signature

**For Trust Administrative Office Use Only**

Date Received: \_\_\_\_\_ Initial: \_\_\_\_\_ Date Processed: \_\_\_\_\_ Initial: \_\_\_\_\_

## CLAIM INSTRUCTIONS

- Complete all sections of this form.
- Attach the following documents:
  - ✓ The Explanation of Benefits form (EOB) issued by an insurance company or claim administrator that shows uncovered health care expenses and the reason why the claim was not paid or not paid in full.
  - ✓ If an EOB is not provided (for vision and Rx claims, or if the expense is not covered by your plan), provide itemized bills which include the patient's name, date of service, type of service, and any plan payments.
  - ✓ Cancelled checks alone cannot be accepted as documentation of expenses.
  - ✓ Please retain a copy of this form and all documentation for your records. Originals will not be returned.

Mail completed form and original documentation to:

Zenith Administrators, Inc.  
FSA Department  
P.O. Box 91082  
Seattle, WA 98111-9182

## REIMBURSABLE HEALTH CARE EXPENSES

**This is a partial list of eligible expenses. A full list is available in IRS Section #213.**

**Acupuncture** – to treat a medical condition

**Ambulance**

**Birth Control Pills**

**Car Modifications for Physically Handicapped Person**

**Chemical Dependency** - at a treatment center

**Chiropractors** - for services within scope of license

**Contact Lenses** - including contact lens solutions and enzyme cleaner

**Crutches** - purchase or rental

**Deductibles and Coinsurance** - not paid by the plan

**Dental Fees** - x-rays, fillings, braces, extractions, false teeth, treatments, etc.

**Drugs and Medicines** - prescriptions and over-the-counter drugs used to treat a medical condition

**Exercise Equipment** – if prescribed by a physician to treat a specific medical condition

**Eye Examinations and Eyeglasses**

**Flu Shots**

**Guide Dog** - purchase for blind or deaf

**Insulin**

**Laboratory Fees**

**Language Training for Child with Dyslexia or Disabled Child**

**Laser Eye Surgery**

**Learning Disability** - tutoring by licensed school or therapist

**Medical Monitoring and Testing Devices** – blood pressure monitor, syringes, glucose kit, etc.

**Medicines** – legally obtained drugs and medicines used to treat a medical condition

**Nursing Service** – amounts spent in wages and other nursing services

**Optometrist** - for services within scope of license

**Orthodontia**

**Ovulation Monitor**

**Oxygen**

**Physical Exams** (not employment-related physicals)

**Physical Therapy**

**Psychiatric Care**

**Psychologist** - for services within scope of license

**Radial Keratotomy**

**Smoking Cessation Programs**

**Sterilization**

**Surgery**

**Vitamins and Mineral Supplements** – only if used to treat a specific medical condition

**Wheelchairs**

**X-ray Fees**

**NOTE:** cosmetic surgery or procedures (such as tooth bleaching) and insurance premiums are not eligible expenses.

## CONTACT INFORMATION

- You may check your FSA account balance and claims history at any time on our web site at [www.zenithfsa.com](http://www.zenithfsa.com) or by using our integrated voice response Flex Hotline at 1-866-206-2345. If you need personalized assistance, contact our FSA Department at 1-800-426-5980, extension 580.