ERISA ADMINISTRATIVE SERVICES, INC.
HEALTH FSA REIMBURSEMENT CLAIM FORM

PERSONAL DATA (Please Print)

Last	*First*	*MI*	*SSN (Last 4)* XXX-XX-
Address	*City*	*State*	*Zip*
Plan Year	*Address Change* ☐ Yes ☐ No	*Email*	
Home/Cell Phone	*Work Phone*	*Preferred form of contact* ☐ Email ☐ Work Phone ☐ Home Phone ☐ 1st Class Mail	

You must provide a receipt showing the date of service, amount of service, description of service, name of service provider, and name of patient or other evidence the expense was incurred (such as an EOB from your Insurance Provider). If this form is incomplete your claim could be denied. Print or type the information requested, then sign and date the form.

	Name of Medical Provider (Doctor, Pharmacy, etc.)	Date Medical Care Provided*	Patient Name	Relationship (Self, Spouse, Child)	Amount that is your responsibility	General Medical Expense Description. (Must Attach Prescription for OTC Medication.)
1					$	
2					$	
3					$	
4					$	
5					$	
6					$	
7					$	
8					$	
9					$	
10					$	
		Total Medical Amount Requested →				$

Please arrange documentation in order listed above.

***Claims for future services will not be accepted**

I request payment from my **Health Flexible Spending Account** (FSA) as indicated above for the expenses listed. I certify that all expenses for which reimbursement is claimed by submission of this form were incurred during a period while I was enrolled in the employer's FSA with respect to such expenses and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. I certify that these expenses will not be claimed as an income tax deduction. I fully understand that I alone am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided, and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense. I am claiming reimbursement only for eligible expenses incurred during the plan year and for my eligible dependents. I authorize my **FSA** to reimburse me by the amount requested.

☐ **I am funding a Health Savings Account (HSA) for this Plan Year.** I understand that by enrolling in and using an FSA, I am ineligible to continue making contributions to my HSA.

☐ **I am NOT funding an HSA for this Plan Year.**

Employee Signature_____ Date_____

SUBMIT YOUR COMPLETED CLAIM FORM TO:

Erisa Trust Company
1200 San Pedro Dr. NE
Albuquerque, NM 87110

Email: support@erisa-trust.com
Phone: (505) 216-7800