University of California
Health & Dependent Care Reimbursement Claim Form

Part I: Employee Information (Please print or click in each box to enter your information.) Control #97001

Employee Name (Last/First/MI)	Date of Birth (MMDDYYYY)	Social Security Number (123456789)
Employee e-mail Address-*Completion of e-mail address will auto-enroll you to receive account e-mail correspondence.*		Daytime Telephone Number ( )

Change of Address Submission – Please check box and complete the information below for address changes only.
Note: *The address change is only temporary; you must contact your employer for a permanent change of address.*

Employee Address	City	
Employee Address (e.g., Apt #, P.O. Box)	State	ZIP
Foreign Country (if applicable)	Country Code (if applicable)	

Part II: Health Care Reimbursement Request

Types of Service Combine all same Type of Service Expenses	Plan Name	Dates of Service Date Format: MMDDYYYY		Covered by Insurance (Y/N)	Explanation of Benefits (EOB) Included (Y/N)	Total Requested Amount
		Beginning Date	Ending Date			
Medical						
Vision						
Prescription						
Dental						
Orthodontics						
Other						
					Total Requested Amount:	**0.00**

Part III: Dependent Care Affidavit and Reimbursement Request

	Dependent's Full Name	Date of Birth	Dates of Service		Total Requested Amount
			Beginning Date	Ending Date	
1					
2					
3					
				Total Requested Amount:	**0.00**

Provider Tax ID:		**Provider Name:**

I provided Adult/Child Care Services to the above individuals in accordance with the amounts and dates that are requested:

Provider Signature: _____ **Date:** _____

To expedite claim payment, please complete and fax form to: 502- 267- 2233

Part IV: Employee Certification for Reimbursement

I hereby certify that:

- The above information is correct;
- I have not received reimbursement previously for these expenses from my Flexible Spending Account(s) or any other plan; and
- The total of any reimbursed dependent care expenses does not exceed my or my spouse's earned income (W-2 Pay) for the year, if less than $5,000.

I understand that:

- Reimbursement is not a guarantee that this payment is tax free;
- Reimbursement of dependent care expenses will reduce and may eliminate completely my ability to claim a dependent care credit on my personal income tax return;
- Dependent care expenses reimbursed through this account cannot be used as a dependent care credit on my personal tax return; and
- Health care expenses reimbursed through this account cannot be used as a deduction on my personal income tax return.

I hereby authorize release of payment through my Flexible Spending Account(s). I hereby authorize SHPS, Inc. or its representatives to obtain necessary information from all physicians, hospitals, medical service providers, dependent care providers, pharmacists, employers, and all other agencies or organizations (this includes other insurers) to consider the claim for reimbursement under my Flexible Spending Account(s).

Employee Signature: _____ **Date:** _____

SHPS, INC.
FSA Processing Center
PO Box 34700
Louisville, Kentucky 40232-4700

FAX Number: 502-267-2233

Reimbursement Request Form Instructions

Claim Submission:

Fax Submission – To expedite your claim payment, fax the completed and signed reimbursement claim form, along with all documentation, to the number listed above. Please send only one claim per transmission. Faxing multiple claim forms with documentation in one transmission will impact the processing of your reimbursement. Please do not include this instruction page with your fax.

Mail Submission – Please mail the completed and signed reimbursement claim form, along with all documentation, to SHPS, INC. at the address listed above.

Fill out the claim form completely and correctly to expedite your claim payment.

Your reimbursement can be sent electronically directly to your banking establishment or mailed to the address of record. You can sign up to receive your reimbursements directly to your bank account via electronic payment, view account history, or learn about our services by accessing mySHPS online services at www.shps.net.

Employee Instructions

Please read these instructions before completing the information requested on the reimbursement claim form.

1. Complete all areas of Part I, "Employee Information."
   Where applicable, complete Part II, "Health Care Expenses" and/or Part III "Dependent Care Expenses."

2. All health care expenses should first be filed under your employer's health care plan or any other coverage you may have before you request reimbursement from your Flexible Spending Account.

3. This form is to be used only to request reimbursement for:

   Health Care Expenses

   - Allowable expenses covered, but not fully reimbursed by any benefit plans. Attach a copy of the plan's Explanation of Benefits statement (EOB) as documentation.
   - Allowable expenses **not** covered by any benefit plans. Attach bills or receipts that indicate the name and address of the provider of service. Please note on the form if the expenses are not covered by a health or dental plan.

   Supporting Documentation - Health Care Expenses

   In addition to the completion of the claim form, the documentation described under either A or B below must be attached.

   A. **Explanation of Benefits statement (EOB):** This is the statement you receive each time you, or a health care provider, submit medical, dental or vision claims for payment to your health, dental or vision care plan. The EOB will show the amount of expenses paid by the plan and the amount you must pay. For expenses that are partially covered by your (or your dependent's) medical, dental or vision plans, you must attach the EOB. If you are covered under a HMO/DMO indicate "Co-pay" on Part II under "Type(s) of Service."

   B. **All Other Expenses: For expenses not covered at all by your (or your dependent's) medical, dental or vision plans, reimbursement requests will not be processed** without acceptable evidence of your expenses. A cancelled check is not considered acceptable evidence. Acceptable evidence includes receipts, which contain the following information:

   - Type of service or product provided
   - Date expense was incurred
   - Name of employee or dependent for whom the service/product was provided
   - Person or organization providing the service/product
   - Amount of expense

   Dependent Care Expenses

   In general, the following rules apply to dependent care expenses:
   - Dependent care expenses qualify if they are for the care of children or other dependents that are physically or mentally incapable of caring for themselves. These expenses must be incurred so that you and your spouse, if married, can work or your spouse can attend school full time.
   - Children must be under age 13.
   - Services provided by a childcare or elder care center must comply with all state and local laws to be an eligible reimbursement expense.

   The annual amount of dependent care claims cannot exceed:
   - Your annual deposit amount up to $5,000 ($2,500 if you and your spouse are filing separate returns), or
   - Your annual salary or your spouse's annual salary, if less than $5,000.

   Supporting Documentation - Dependent Care Expenses

   - For allowable Dependent (Day) Care expenses, attach a copy of the bill or signed receipt, or have the provider complete Part III, "Dependent Care Affidavit and Reimbursement Request" on the reverse side.
   - Requests **will not be processed** without the Tax ID number for all providers.

4. Read the Employee Certification for Reimbursement statement, then sign and date the form where indicated.