

# HR Concepts, LLC

"Your Third Party Administrator of Choice"

## Universal Receipt Submission/Claim Form

### Part I. Employee Information ( Please check if this is a new address)

Employee Name: _____	SS # _____ - _____ - _____
Mailing Address: _____	City: _____ St.: _____ Zip: _____
Email Address for All Correspondence: _____	
Telephone: _____	Employer Name: _____ Plan Year: _____

### Part II. Instructions for submitting form (PLEASE READ CAREFULLY)

1. Fill out entire form and make sure to indicate below in the appropriate section if you are submitting a claim for reimbursement or if you are sending us your receipts for verification of an expense you were already reimbursed for because you used the VISA we sent to you.
2. If you are submitting for reimbursement of an FSA claim, check whether the claim is for the current plan year or previous plan year.
3. Reimbursement is only for expenses that will not be reimbursed from any other source. These expenses must have been incurred within the plan year. Some plan designs allow claims to be incurred 75 days after the end of the plan year, please verify before submitting. You have up to 90 days after the end of a plan year to submit expenses that are eligible for reimbursement.
4. All 3rd party documentation supporting your request for reimbursement must be attached. This supporting documentation must show date of service (Not the payment date), amount of expense that you are responsible for, who it was for, and a brief description of expense.
5. Dependent Care Reimbursement requests must have a signature from the provider as well as the tax ID # of the provider filled in below.
6. Dependent Care Reimbursements may be submitted in advance of future service dates. You will receive a reimbursement check from your account according to your payroll cycle. The amount you receive will be equal to your payroll deduction or account balance, whichever is greater. If the amount of the reimbursement check is going to exceed your actual expense for the said time frame, you are required to notify us so that we may adjust the claim.
7. For Healthcare Reimbursement Arrangement (HRA) claims, please indicate if you want us to send you a check, directly deposit the money into your checking account, or place the money onto your VISA we provide you. In most cases an Explanation of Benefits (EOB) from the insurance carrier will be mandatory.

### Part III. Purpose of this form (Please check only one box and fill in the appropriate Section below)

- Healthcare FSA Claim Submission (Complete Section IV. below)
- Dependent Care FSA Claim Submission (Complete Section V. below)
- Healthcare Reimbursement Arrangement (HRA) Claim Submission (Complete Section VI. below)
- Receipt Submission For Verification Of VISA Use For an FSA or HRA Claim (Complete Section VII. below)

### Part IV. Healthcare FSA Claim Information

\* Please check the reimbursement option you prefer:  Check mailed  Direct Deposit

\*Please Check Appropriate Plan Year:  Current Year's Claim  Previous Year's Claim

Name of Covered Person (Self, Spouse, Dependent)	Date of Service (Not payment Date)	Type of Service (Medical, Dental, Vision, Dependent Care)	Description of Services	Amount of Claim

Total of Healthcare FSA Claim: \$ \_\_\_\_\_

(Continued on Back)



Flex Plans • HSA's • Commuter Plans • HRA's • Dental Plans • COBRA

Phone: 603-647-1147 • Fax: 1-866-978-7868 • email: info@hrconcepts.biz

www.HRConcepts.biz • 111 Charles Street • Manchester, NH 03101

**Part V. Dependent Care FSA Claim Information**

\* Please check the reimbursement option you prefer:  Check mailed  Direct Deposit

\*Please Check Appropriate Plan Year:  Current Year's Claim  Previous Year's Claim

Name of Provider	Date of Service (Not payment Date)	Type of Service (Daycare/Baby Sitting/ Preschool/ Day Camp/Etc)	Provider Signature & TAX ID # (Have Provider Sign Here or Attach their Receipts)	Amount of Claim

Total of Dependent Care FSA Claim: \$ \_\_\_\_\_

**Part VI. Healthcare Reimbursement Arrangement (HRA) Claim Information**

Please check the reimbursement option you prefer (Check, Direct Deposit, Money placed on Debit Card)

Check mailed  Direct Deposit  Money Authorized on Debit Card

---

If you have used all your HRA funds from your employer and your claim is not completely covered by these funds, please check the box below if you want HR Concepts to apply your remaining unpaid balance of this claim from any funds available in your Healthcare FSA:

Submit any unpaid HRA claims toward my Healthcare FSA

Name of Covered Person (Self, Spouse, Dependent)	Date of Service (Not payment Date)	Type of Service (Medical, Dental, Vision, Dependent Care)	Description of Services	Amount of Claim

Total of Healthcare Reimbursement Arrangement (HRA) Claim: \$ \_\_\_\_\_

**Part VII. Receipt Submission For Verification Of VISA Use For an FSA or HRA Claim**

Please check which account the reimbursement should have been taken from

Flexible Spending Account (FSA)  Healthcare Reimbursement Arrangement (HRA)

Name of Covered Person	Date of Service	Type of Service	Description of Services	Amount of Claim

Total of VISA Charges: \$ \_\_\_\_\_

**Part VIII. Signature**

The above statements and submitted information for reimbursement are true. I am only submitting for reimbursement for eligible expenses that I incurred for myself or legal dependents. I certify that I have not been nor will I be reimbursed for these submitted reimbursements from any other source. I further certify that I will not claim these expenses as a tax deduction.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_