FAX: 585-389-7003

Submit or view claims **ONLINE: https://benefits.paychex.com**

Paychex Employee Services: 877-244-1771, available 24/7

FOR OFFICE USE ONLY

Docket # _____

PAYCHEX®

Flexible Spending Account (FSA) Reimbursement Claim
Unreimbursed Medical Expenses

EMPLOYEE INFORMATION (print)

Employee Name _____ Company Name _____

Social Security Number (last 4 digits) _____ Employee Telephone Number (___) _____ - _____

E-mail Address _____

Visit **https://benefits.paychex.com** at any time to submit claims **ONLINE** or learn the status of your claim.

All claim reimbursements will be processed within 2 business days upon receipt of the completed claim form and all supporting documentation.

INSTRUCTIONS CHECKLIST:

- ☐ Enclose copies of all itemized bills and/or receipts from your provider or a copy of your orthodontia services contract, if applicable. Use blue or black ink only to identify FSA items on receipts. **Do not use highlighter. We will not accept copies of personal checks, cancelled checks, or credit card receipts as verification of service.**
- ☐ Verify that bills and receipts contain:
  - date of service
  - description of service
  - cost of service
  - provider's name
  - provider's address
  - prescription name (if expense is for a prescription)
- ☐ If you have a Health Savings Account (HSA) in addition to your FSA, use your FSA to pay for vision, dental, and preventative medical expenses as well as any remaining FSA-eligible expenses not covered by your HSA plan.
- ☐ **Sign your claim form** and fax it to the number noted above. Retain a copy for your records.
- ☐ If you prefer, mail your claim to: Paychex, Inc., FSA Claims, PO Box 3000, Henrietta, NY 14467-3000.

Claim	Name of Service Recipient	Relationship to Employee	Service Date(s)	Service Description	Service Provider	Amount
SAMPLE	John Doe	☐ Self ☐ Spouse ☑ Dependent	07/07/07	☑ Medical ☐ Dental ☐ Vision ☐ Pharmacy	Dr. Jones	$521.43
01		☐ Self ☐ Spouse ☐ Dependent		☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy		$
02		☐ Self ☐ Spouse ☐ Dependent		☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy		$
03		☐ Self ☐ Spouse ☐ Dependent		☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy		$
04		☐ Self ☐ Spouse ☐ Dependent		☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy		$
					TOTAL	$

If you have more claims, please complete additional Reimbursement Claim forms.

CLAIM INFORMATION

I certify that the information here is true and correct; that the expenses incurred were for myself, spouse, or dependents; and that these expenses are not reimbursable under any other health plan coverage.

Employee Signature _____ **Date** _____ / _____ / _____