



Reimbursement Claim Form

Please complete this form to request reimbursement of expenses incurred by you and/or eligible dependents. Itemized documentation of each expense must be provided. For questions, contact Customer Care at 877-933-3539

Participant Information	
<u>Participant Name:</u>	
<u>Employer Name:</u>	CITY OF MILWAUKEE
<u>Employee Number/ID:</u>	
<u>Email address & Home Address:</u>	

Please list each eligible expense below

Under the **Benefit Type** column, select one of the following benefit codes for each expense.

FSA – Health FSA	LPFSA - Limited Purpose Health FSA	DCA – Dependent Care Account	HRA -Health Reimbursement Arrangement
TRN – Transit	PKG – Parking	DVFSA – Dental/Vision Health FSA	PRA – Premium Reimbursement Account

Under the **Service Code** column, select one of the following service codes.

MT – Mass Transit	PK – Parking	MD – Medical	RX – Prescription Drugs
OT – Over-the-Counter	VS – Vision	DN – Dental	IP – Individual Premiums

Paid with TASC Card	Benefit Type	Date of service	Service Code	Service Provider	Dollar Amount

For quick reimbursement, file online via your employee portal or Mobile App!

Submit your claim form with supporting documentation via FAX to 877-231-1287.

To the best of my knowledge and belief, my statements on this Request for Reimbursement are complete and true. I am requesting reimbursement only for eligible expenses incurred during the applicable Plan Year and for eligible Plan Participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I understand that the IRS regulates my FlexSystem account and that these guidelines are implemented as a means of ensuring compliance and approval for reimbursement. I further understand that it is my responsibility to comply with these guidelines and to avoid submitting duplicate or ineligible requests, as doing so may delay payment. I authorize my Flexible Spending Account balance to be reduced by the amount requested.

Signature	Date
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