



O'Neill Public School Flex Request for Reimbursement Form

Instructions: Please print or type the information below.

- | | |
|---|--|
| 1. Sign and Date form | 4. Receipts attached must be clear and legible. |
| 2. The Total Dependent Care Reimbursement request box must be completed. | 5. Allow 48 business hours to check status of reimbursement request. |
| 3. The Medical Care Total requested box must be completed. | 6. Please maintain copies of all receipts for your records. |

Employee Information **Check here if address change**

Participant's Social Security Number		Participant's E-Mail Address	
Last Name	First Name	Middle Initial	
Street Address	City	State	Zip

By submitting this claim form, I request reimbursement from my OPS Flex account(s) as listed below. I agree to the Terms and Conditions outlined in my employer's Summary Plan Description. I certify and warrant to OPS that these are eligible medical and/or dependent care expenses that I or my dependents have incurred, are not cosmetic in nature, and cannot be reimbursed from any other source. I will maintain copies of all documentation for my records.

Participant's Signature _____ Date _____

Dependent Care Claim Information

For Dependent Care expenses that allow you and your spouse, if applicable, to work. You may file your claim in one of the following ways:

Option 1 must include:

-OR-

Option 2 must include:

1. Date(s) of service (only services received; no future dates).
2. Reimbursement requested (This amt is = to or < than amt charged).
3. Name and age of the dependent receiving care.
4. Attached receipts (receipts must have exact dates of services provided).

1. Date(s) of service (only services received; no future dates).
2. Reimbursement requested (This amt is = to or < than amt charged).
3. Name and age of the dependent receiving care.
4. Provider name, phone number, and dated signature.

Name/Age of Dependent Receiving Care	Date(s) Services Were Provided	Amount Requested

Total Dependent Care
Reimbursement Requested
\$ _____

Dependent-Care Provider Business Name _____ Phone Number _____

Provider's Signature _____ Date _____

Medical Care Flex Spending Account (FSA) Claim Information

For Medical Care Expenses, an Explanation of Benefits (EOB) from your insurance company or other receipt(s) must be submitted. **The EOB and/or attached bills must contain the following items to be processed and approved:**

- | | | | | |
|-----------------|---------------------|---------------------------|---------------------------------|----------------|
| 1. Patient Name | 2. Service Provider | 3. Description of Service | 4. Date(s) Service Was Provided | 5. Amount/Copy |
|-----------------|---------------------|---------------------------|---------------------------------|----------------|

List each receipt separately in the space(s) below. Use additional forms if necessary. A total **must** be indicated in the Total block below. Use the Provider Certification space below only if no receipt is attached. **Do not** indicate "see attached" in the spaces below.

Patient Name	Service Provider	Description of Service	Date Service Was Provided	Requested Amount

Provider Certification

In lieu of receipts or EOB(s) the provider of the service can certify that the above listed medical care expenses have been incurred and only incurred by either the participant or his/her dependents. Any other expenses must have receipts or a separate completed form. Failure to complete all items will result in an invalid claim request.

Provider Name and Address _____ City _____ State _____ Zip _____

Provider's Signature _____ Date _____

TOTAL \$

I certify that the Medical Care expenses listed above were incurred by the patient named above.

Helpful Tips for Filing Your Claim

1. Complete, sign and date the Flex Request for Reimbursement Form. Failure to complete all areas will result in claim rejection and a delay in processing and reimbursements. Do not indicate "See Attached" in any field. Description of service should provide as much detail as possible. If a provider certification is used, the provided must sign and date each new claim form.
2. Submit documentation that is clear and legible. Do not highlight information; these areas often turn black when scanned. In addition, double check to make sure all documentation is clearly visible and not overlapped, written through, or cut off if photocopied.
3. Verify that services received are eligible expenses. See below or refer to your *Participant Handbook* for general guidance.
4. The deadline or run-off period for claims submission is determined by your employer. For more information on the run-off period, refer to your Summary Plan Description or contact your employer. To avoid delays, submit your claims at least two week prior to the end of your run-off period.
5. Additional reimbursement forms can be obtained from O'Neill Public Schools Administrative Offices.

Sample Health Flex Spending Account Expenses

This list is not all-inclusive; for more detailed information, refer to the *Participant Handbook*. Unreimbursed medical expenses are reviewed according to the regulations of the Internal Revenue Code Section 125. All claims must be substantiated, and appropriate documentation must be provided. *Some expenses may require additional documentation from your doctor or health care provider.*

Insurance

Eligible

Deductibles, copayments, and
Coinsurance for medical care plans

Ineligible

All premiums/contributions for insurance
Long-term care plans
Expenses paid totally by your health plan

Medical Equipment

Eligible

Wheelchairs/crutches
Blood sugar monitors
Oxygen equipment
Hearing aids, batteries, or hearing aid repairs

Ineligible

Equipment replacement insurance and/or
warranties
Vacuum cleaners for individuals with dust
allergies

Vision Care

Eligible

Prescription eyeglasses
Contact lenses and cleaning solutions
Prescription sunglasses

Ineligible

Lens replacement insurance/warranties
Protection plans
Coatings/tints not used to treat
a medical condition

Treatment/Therapies

Eligible

Prescribed weight loss programs to treat a medical
condition (not including foods)
Diagnostic services (e.g., X-ray and MRI treatments)
Smoking cessation programs
Fertility treatments

Ineligible

Illegal treatments
Physical treatments for general well-being or relaxation
(e.g., massage therapy)

Dental/Orthodontic Care

Eligible

Routine exams, cleaning, and X-rays
Artificial teeth/dentures
Braces and orthodontic services

Ineligible

Teeth bleaching/whitening
Tooth bonding that is not medically necessary
(e.g., cosmetic veneers)

Drugs

Eligible

Prescription drugs to treat a medical
condition
Birth Control
Insulin

Ineligible

Dietary supplements for general health,
to include vitamins and herbs
Drugs for cosmetic purposes

Fees/Services

Eligible

Physician consultation fees
Routine office visit
Nursing services for care of a specific ailment
Legal sterilization

Ineligible

Cosmetic procedures that improve appearances but do not
meaningfully promote the proper function of the body or
treat an illness/disease
Payments to domestic help for nonmedical services
Retainer or concierge fees

Miscellaneous Charges

Eligible

Sales tax associated with an eligible item
Transportation expenses primarily for
medical care, to include mileage, bus, taxi,
parking fees and/or tolls

Ineligible

Divorce, even when recommended by a psychiatrist
Diaper service
Toiletries or cosmetic items
(e.g., toothbrush, soap, lotion, etc.)
Maternity clothes

Key Numbers

O'Neill Public Schools
Administrative Office

Phone – 402-336-3775

Fax – 402-336-4890

Submission Guidelines

Please allow 48 hours for the receipt of your faxed form before calling to inquire about your reimbursement.

Note: Please use discretion when faxing your personal information. You bear full responsibility for any inappropriate use or disclosure that may arise in connection with your transmission of information to O'Neill Public Schools.