DELTA HEALTH SYSTEMS

Please mail completed form to:

Delta Health Systems
6575 So. Redwood Road, Ste. 300
Taylorsville, UT 84123
Toll-free: 888-478-7331
Fax: 801-412-8542

Flexible Spending Account Claim Form

Instructions: Complete the appropriate spaces on this form and attach the Explanation of Benefits or proof of expenses which includes provider's name, date of service, and type of services provided. Please refer to your Summary Plan Document for timeframes and guidelines on claims submission.

Note: The documentation necessary to reimburse an eligible Over the Counter (OTC) drug expense will be similar to that requested for all other types of health care FSA expenses. OTC items require a physicians prescription and we require an itemized receipt(s) that includes the name of the provider, the name of the product purchased, the cost of the item, and the date it was purchased. Please see your HR representative for a listing of eligible OTC expenses.

Employer **Group#**

Employee Name **Social Security Number**

Address **Street** **City** **State** **Zip**

Telephone Number **Email Address**

Type of Expense(s)	**Amount Requested for Reimbursement**
☐ Medical ☐ Dental ☐ Vision ☐ Rx	$_____
☐ Dependent Care	$_____
☐ Qualified Transportation ☐ Parking	$_____

For Dependent Care Provider if NO receipt is attached

Dates of Service_____ Provider's ID #_____

Providers Statement: I verify that child care services were provided for the amount and dates indicated above.

_____

Provider Signature Date

I, the undersigned, request reimbursement for the eligible expenses listed for myself and/or any eligible dependents. I certify these expenses are eligible for reimbursement under the Flexible Spending Account sponsored by my employer. I have not been and will not be reimbursed for these expenses from this or any other benefit plan and have/will not included them as itemized deductions or as a tax credit on my personal income tax returns.

Signature of Employee **Date**