Health Care Flexible Spending Account (HCFSA) Program

HCFSA REIMBURSEMENT REQUESTS

Please read "Instructions and Important Information" on the reverse side before completing this form and refer to your enrollment information for HCFSA rules and regulations. If the service was provided for more than one day, show the beginning date and the ending date of the service. *Each claim must be separated by patient, date/type of service and dollar amount.*

EMPLOYEE (PARTICIPANT) INFORMATION (PLEASE TYPE OR PRINT CLEARLY)

LAST NAME	FIRST NAME	MI.	LAST FOUR OF SOCIAL SECURITY NUMBER

HOME ADDRESS - NUMBER AND STREET ☐ *CHECK HERE IF THIS IS A NEW ADDRESS* | APT. NO.

CITY | STATE | ZIP CODE | EMAIL ADDRESS:

HOME OR CELL (DAYTIME) PHONE NUMBER ( ) - | WORK PHONE NUMBER ( ) - | AGENCY NAME (NOT DIVISION)

1

PATIENT LAST NAME | PATIENT FIRST NAME | MI.

DATE(S) OF SERVICE (MM/DD/YY) FROM _____/_____/_____ TO _____/_____/_____

TYPES OF SERVICE ☐ Medical ☐ RX ☐ OTC ☐ Dental ☐ Vision ☐ Hearing Aid

REIMBURSEMENT AMOUNT REQUESTED $

CLAIM PERIOD (CHECK ONLY ONE) ☐ 2025 Plan Year (services incurred 1/1/25 - 12/31/25) ☐ 2024 Plan Year (services incurred 1/1/24 - 12/31/24)

All Claims with Service dates up to 3/15/2025 will be applied to outstanding balance in Plan Year 2024.

PROVIDER'S NAME

2

PATIENT LAST NAME | PATIENT FIRST NAME | MI.

DATE(S) OF SERVICE (MM/DD/YY) FROM _____/_____/_____ TO _____/_____/_____

TYPES OF SERVICE ☐ Medical ☐ RX ☐ OTC ☐ Dental ☐ Vision ☐ Hearing Aid

REIMBURSEMENT AMOUNT REQUESTED $

CLAIM PERIOD (CHECK ONLY ONE) ☐ 2025 Plan Year (services incurred 1/1/25 - 12/31/25) ☐ 2024 Plan Year (services incurred 1/1/24 - 12/31/24)

All Claims with Service dates up to 3/15/2025 will be applied to outstanding balance in Plan Year 2024.

PROVIDER'S NAME

3

PATIENT LAST NAME | PATIENT FIRST NAME | MI.

DATE(S) OF SERVICE (MM/DD/YY) FROM _____/_____/_____ TO _____/_____/_____

TYPES OF SERVICE ☐ Medical ☐ RX ☐ OTC ☐ Dental ☐ Vision ☐ Hearing Aid

REIMBURSEMENT AMOUNT REQUESTED $

CLAIM PERIOD (CHECK ONLY ONE) ☐ 2025 Plan Year (services incurred 1/1/25 - 12/31/25) ☐ 2024 Plan Year (services incurred 1/1/24 - 12/31/24)

All Claims with Service dates up to 3/15/2025 will be applied to outstanding balance in Plan Year 2024.

PROVIDER'S NAME

TOTAL REIMBURSEMENT AMOUNT REQUESTED (1+2+3) $ 0.00

DIRECT DEPOSIT INFORMATION - For initial enrollment in Direct Deposit or changes only (MUST ATTACH VOIDED CHECK)

***ABA NUMBER:** CHECKING ACCOUNT - THE ABA NUMBER IS THE FIRST NINE (9) NUMBERS PRIOR TO THE ACCOUNT NUMBER AT THE BOTTOM LEFT CORNER OF THE CHECK. SAVINGS ACCOUNT - CONTACT YOUR BANK FOR THE ABA NUMBER, IF NOT KNOWN. ****ACCOUNT NUMBER:** SEE CHECK, PASSBOOK, OR ACCOUNT STATEMENT FOR ACCOUNT NUMBER.

Account Type: (Check only one)	Person(s) Named on Account (Please Print Clearly)	ABA Number* (Must be 9 Digits)	Attach VOIDED Check Here
❑ Checking ❑ Savings	Person 1: _____ Person 2: _____	Account Number** (Please Write)	

EMPLOYEE (PARTICIPANT SIGNATURE)

The above is a true and accurate statement of unreimbursed health care expenses incurred by me and/or my eligible dependent(s) on the date(s) indicated. I certify that I and/or my eligible dependent(s) have incurred these expenses and have not been previously reimbursed and are not eligible for reimbursement through any other plan. I understand that expenses reimbursed herein cannot be deducted from my or anyone else's individual Federal Income Tax return. All claims submitted by me comply with the rules and definitions as set forth on the reverse side of this form. I understand that the Internal Revenue Code and the HCFSA Plan Document are the final authority in determining eligible expenses.

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

Did you remember to: ✓ **Complete all sections?** ✓ **Choose the correct claim period?** ✓ **Sign and date the form?** ✓ **Attach EOB statement(s), bill(s) and appropriate documentation?**

Please submit this form electronically to: **https://nyc-fsa.leapfile.net**

Print Form | Clear Fields

The Health Care Flexible Spending Account Program is a division of the Office of Labor Relations' Flexible Spending Accounts Program

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA) PROGRAM CLAIMS FORM

nyc.gov/fsa

HCFSA

INSTRUCTIONS AND IMPORTANT INFORMATION

1. A" Plan Year" is the calendar year (January 1-December 31) or for a newly eligible employee, any remaining portion thereof.

   A "Grace Period" allows participants to submit claims that may be incurred during the Grace Period and reimbursed using the remaining balance from the applicable Plan Year's account. (See below.)

   - The ***Grace Period for Plan Year 2025*** is from January 1, 2026 through March 15, 2026. The HCFSA claim may be incurred during this period and reimbursed using the remaining balance from the participant's previous Plan Year's account.
   - The ***Grace Period for Plan Year 2024*** is from January 1, 2025 through March 15, 2025. The HCFSA claim may be incurred during this period and reimbursed using the remaining balance from the participant's previous Plan Year's account.

   A "Claims Run-Out Period" is from January 1 through May 31 following the end of the current Plan Year, during which you may submit any outstanding or pending claims incurred during the Plan Year or the Grace Period. Claims received after May 31 will **not** be processed.

2. When submitting a claim, please indicate if the claim should be applied to Plan year 2024 or 2025. If you participated in the HCFSA 2024 Plan Year and have a balance, any claims with service incurred by 3/15/2025 will be applied to your balance.

3. After the Claims Run-Out Period has ended, any unclaimed year-end balance in your account will not be carried into the next Plan Year and will be forfeited.

4. Reimbursement can only be made for expenses resulting from services that have been received in the applicable Plan Year. No reimbursement can be made prior to services being received.

5. The minimum reimbursement amount requested must total $50.00, unless your current account balance is less than $50.00.

6. Only claims received by the 15th day of the month will be processed for that month. Once your claims are approved, you will receive reimbursement at the end of the following month.

7. Attach the Explanation of Benefits (EOB) statement from your health insurance carrier(s) for medical expenses (i.e., deductibles, co-payments) and the EOB from your Welfare Fund for dental, vision and/or hearing expenses. Also, attach an itemized bill or receipt from your provider(s) for all eligible expenses. The date(s) of service on the claims form must match the date(s) of service on the EOB and the receipt or billing statement.

   Each EOB, bill, receipt or claims form must contain the following information:

   - Name of patient receiving service
   - Date(s) and Types of service
   - Amount charged for service
   - Name of provider rendering service

   The HCFSA Program reserves the right to request additional documentation.

8. Submitting Prescription Claims: For prescription claims, submit a copy of the product box containing the name of the prescribed drug, if an itemized receipt is not available. You must attach a doctor's prescription for the following over-the-counter (OTC) drug claims: sunscreen, vitamins and nutritional supplements. Submit a receipt for all other OTC claims. Please refer to the FSA Program Brochure for a list of eligible OTC items.

9. Definitions:
   a) Eligible Medical Expense: An expense which has been incurred by the participant for qualifying health care expenses provided for an eligible health care recipient on or after the benefit effective date and which is eligible for reimbursement pursuant to the terms of the HCFSA Program

   b) Qualifying Health Care Expense: An expense incurred for an eligible medical service which is: (i) performed in regard to an eligible health care recipient; (ii) not reimbursable by a health insurance carrier and/or Welfare Fund; and (iii) not for the payment of health insurance premiums

      Note: Any expense defined by the IRS as a non-deductible expense for income tax purposes shall be ineligible for reimbursement under HCFSA. Furthermore, an expense deductible for income tax purposes does not necessarily mean that it qualifies for reimbursement under this Program.

   c) Eligible Health Care Recipients:(i) the participant, who is eligible to be covered under the City of New York Employee Health Benefits Program (EHBP); (ii) the participant's spouse, who is eligible to be covered under the City of New York EHBP; and (iii) the participant's children who are eligible for coverage under the City of New York EHBP, including the participant's adult children who do not attain age 27 by the end of the Plan Year.

      Note: Domestic partners/civil unions are not eligible health care recipients under HCFSA.

10. You may obtain additional claim froms on the FSA website at nyc.gov/fsa. Be sure to sign and date this form. You may submit your completed form(s) in the following ways:
    - Forms/documents can be sent via secure email to: https://nyc-fsa.leapfile.net
    - Forms can be mailed to:
      The Flexible Spending Accounts Program
      P.O. Box 707
      Bowling Green Station
      New York, NY 10274
    - Express mail forms should be sent to:
      NYC Flexible Spending Accounts Program - 2024
      22 Cortlandt Street, 28th Floor
      New York, NY 10007

Note: You do not need to submit Direct Depoist information if the Flexible Spending program has your information on file. If you have not enrolled in Direct Depoist or experience a change in Direct Depoist please provide the Direct Depoist information as well as a voided check. If you are submitting multiple claims you only need to submit one voided check.