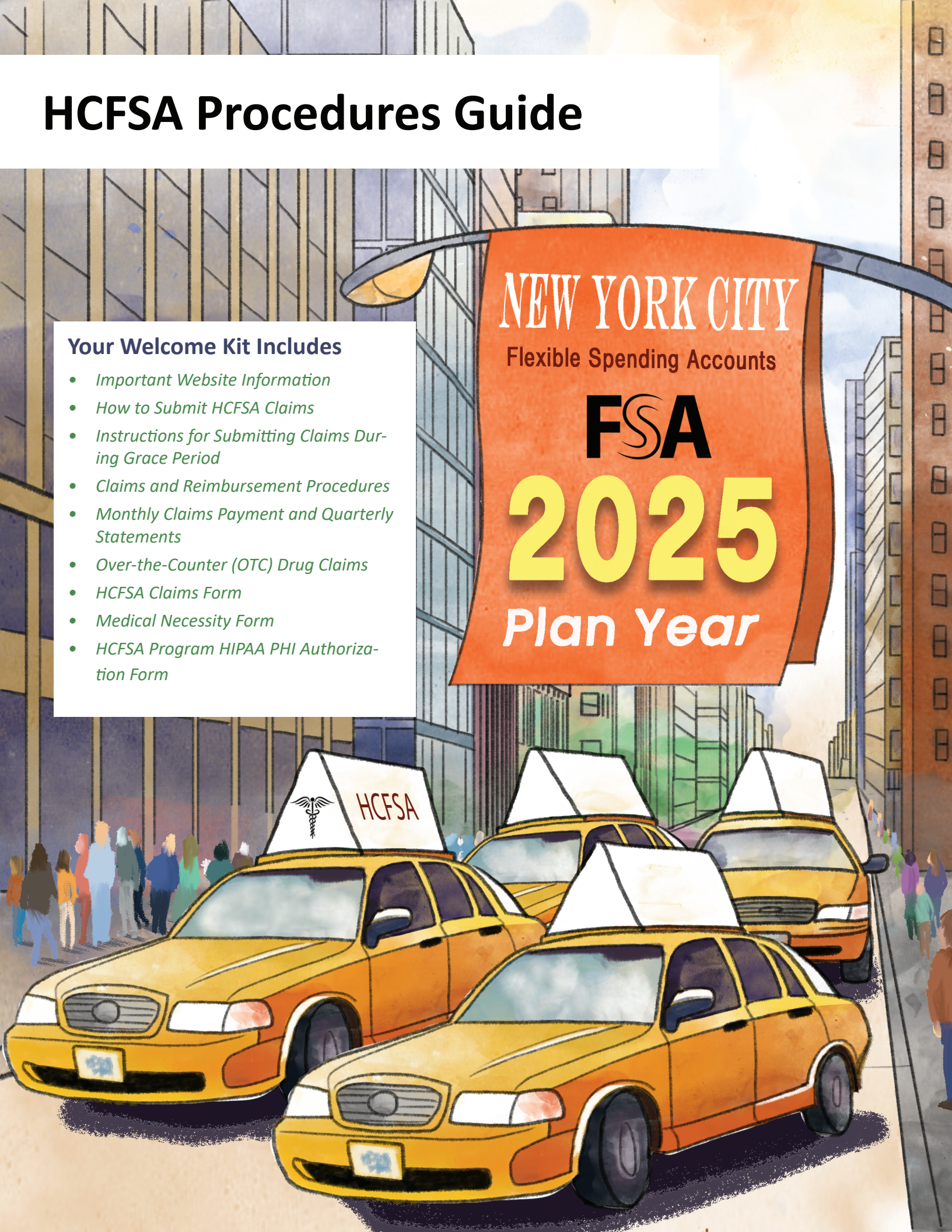
HCFSA Procedures Guide



Your Welcome Kit Includes

- *Important Website Information*
- *How to Submit HCFSA Claims*
- *Instructions for Submitting Claims During Grace Period*
- *Claims and Reimbursement Procedures*
- *Monthly Claims Payment and Quarterly Statements*
- *Over-the-Counter (OTC) Drug Claims*
- *HCFSA Claims Form*
- *Medical Necessity Form*
- *HCFSA Program HIPAA PHI Authorization Form*

Please visit the Flexible Spending Accounts (FSA) Program Website at nyc.gov/fsa for detailed information on:

- *The Dependent Care Assistance Program (DeCAP)*
- *The Health Care Flexible Spending Account (HCFSA) Program*
- *The MSC Health Benefits Buy-Out Waiver Program*
- *The MSC Premium Conversion Program*

You can select Forms & Downloads for:

- *Plan Year Brochures and Enrollment/Change Forms*
- *FSA Program Claims Forms*
- *Medical Necessity Form*
- *HCFSA Program HIPAA PHI Authorization Form*
- *FSA Direct Deposit Enrollment/Change/Cancellation Form*

How to Submit HCFSA Claims

Plan Year and Grace Period: You may file claims from January 1 through December 31. You may also submit claims incurred during the Grace Period following the end of the Plan Year (January 1st through March 15th) using the remaining balance in your Plan Year account, if any.

Claims Run-Out Period: If you need time to obtain additional documentation from your health plan(s) and/or Welfare Fund(s) for claims incurred during the Plan Year or the Grace Period, you may file claims from January 1st through May 31st following the end of the Plan Year. The last day to submit all claims is May 31 st.

Remaining expenses should be submitted to secondary plans BEFORE HCFSA (i.e: union welfare fund benefits/ SMMP for MBF/OSA members)

Medical Claims

#1 - Submit all medical claims to your primary health plan

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#2 - Submit remaining expenses to your secondary health plan or Welfare Fund's Superimposed Major Medical Plan (if applicable)

↓

#3 - Obtain Explanation of Benefits Statements (EOBs) from both primary and secondary health plans

↓

#4 - Complete an HCFSA Claims Form for remaining expenses and submit it along with your EOBs

Over-the-Counter (OTC) Drug Claims (with prescription only)

#1 - Follow the checklist on the OTC drug claims instruction sheet enclosed in the HCFSA Procedures Guide to determine whether the product is eligible for reimbursement

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#2 - Compile copies of doctor's prescriptions and itemized receipts from OTC drug purchases and indicate recipient's name on OTC receipt

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#3 - Make copies of product boxes if receipts do not indicate which OTC drugs you purchased

↓

#4 - Complete an HCFSA Claims Form and submit it with your receipts and doctor's prescription

Office Visit Co-Pays and Prescription Drug Co-Pays

#1 - Compile receipts (or EOBs) indicating your co-pays

↓

#2 - Complete an HCFSA Claims Form and submit it along with your EOBs or receipts

Dental and Vision Care Claims

#1 - Submit all dental and vision care claims to your Union or Welfare Fund

↓

#2 - Obtain EOBs from your Union or Welfare Fund

↓

#3 - Complete an HCFSA Claims Form for remaining out-of-pocket expenses and submit it along with your EOBs

Hearing Aid Claims

#1 - Submit all hearing aid claims to your Union or Welfare Fund's secondary health plan such as a Superimposed Major Medical Plan (if applicable)

↓

#2 - Obtain EOBs from your Union or Welfare Fund's secondary health plan such as a Superimposed Major Medical Plan (if applicable)

↓

#3 - Complete an HCFSA Claims Form for remaining out-of-pocket expenses and submit it along with your EOBs

Instructions for Submitting Claims During HCFSA Grace Period

What is the HCFSA Grace Period?

Previously, under the "Use It or Lose It" Rule mandated by the IRS, any amount contributed to your HCFSA but not claimed by the end of the Plan Year was forfeited. Now the IRS permits a Grace Period, which is an additional time period during which you may submit claims for eligible medical services received from January 1 through March 15 following the end of the Plan Year if you have a remaining balance in your previous Plan Year's account. The Grace Period affords you an opportunity to use any remaining funds without having to forfeit your entire balance after the last day of the Plan Year.

The Grace Period during which you may use your remaining balance in your Plan Year account is from January 1st through March 15th following the end of the Plan Year. (NOTE: The Claims Run-Out Period described below also applies to claims submitted during the Grace Period).

What is the Difference Between the Grace Period and Claims Run-Out Period?

The Claims Run-Out Period, which runs from January 1st through May 31st following the end of the Plan Year, is an additional time period during which you may submit outstanding or pending claims for services received during the Plan Year or Grace Period.

For example:

You received a medical service during the Plan Year, but did not receive an Explanation of Benefits (EOB) prior to the last day of the Plan Year (December 31st) in order to submit a claim on time. You will have until the last day of the Claims Run-Out Period (May 31st) to obtain your EOB and submit your claim.

You received a medical service during the Grace Period, but did not receive an EOB prior to the last day of the Grace Period (March 15th) in order to submit a claim on time. You will have until the last day of the Claims Run-Out Period (May 31st) to obtain your EOB and submit your claim.

What Happens to My Remaining Balance from the Plan Year if I Do Not Submit a Claim by May 31st?

According to the IRS, if you do not submit a claim incurred during the Plan Year or Grace Period by May 31st following the end of the Plan Year, any amount remaining in your Plan Year account will be forfeited.

Health Care Flexible Spending Account (HCFSA)
Program Claims and Reimbursement Procedures

Please follow these procedures for the expedient processing of your claims and note that medical care must be for expenses to diagnose, cure, mitigate, treat or prevent disease or to affect any structure or function of the human body.

1. Submit your Claims Forms once a month, on or before the 25th day of the month. (Minimum reimbursement amount requested must total $50.00 unless current account balance is less than $50.00).

2. Attach the following documentation to Claims Forms:
   - Itemized bill or receipt from service provider, and
   - Explanation of Benefits (EOB) statement (issued by your health insurance carrier for medical expenses or Welfare Fund for dental, vision and/or hearing expenses, indicating benefits received and services for which payment has been requested)
   - Copy of product box for over-the-counter (OTC) drugs if receipt does not indicate name of the drug, and doctor's prescription.

3. Each EOB, bill, receipt, and Claims Form must contain the following information:
   - Name of patient receiving service
   - Amount of charge for service
   - Type of service
   - Name of provider rendering service
   - Date of service

Note: The date(s) of service(s) on the Claims Form must match the date(s) of service(s) on the EOB and the receipt or billing statement.

To obtain an EOB for medical, dental, vision, or hearing expenses, deductibles, or co-payments covered by any group health plan, you must first submit your expenses to your health insurance carrier and/or Welfare Fund. The health insurance carrier and/or Welfare Fund will send you an EOB stating what amount, if any, is covered by your health plan and/or Welfare Fund.

Please be advised that even if you know an incurred health care expense is not covered by your health insurance carrier and/or Welfare Fund, you still need to submit the claim first to your health insurance carrier and/or Welfare Fund to receive an EOB from them stating that your claim is not covered. In a situation where an EOB cannot be obtained, you may submit to our office, in lieu of the EOB statement, a copy of your health insurance and/or Welfare Fund Plan Document stating that the health care expense is not covered by your health insurance carrier and/or Welfare Fund.

If you have any further questions regarding your HCFSA claims, please call the HCFSA Administrative Office at (212) 306-7760.

Note: This instruction sheet was formulated to assist you in the submission of your claims. Please refer to this sheet throughout the Plan Year.

Health Care Flexible Spending Account (HCFSA)
Program Claims Payments and Quarterly Statements

Monthly Claims Payment Statement

If claims are received and approved by the 25th day of each month, you will receive reimbursement by the end of the following month. At the end of each month, you will receive a monthly claims payment statement indicating claims processed for that month and amount of reimbursement issued.

The dollar amount of a claim that exceeds your annual benefit amount will not be paid and will be listed under "Amount Unpaid." Your available balance is equal to the amount you elected to contribute to the program, less the annual administrative fee and the total amount of claims paid from your account.

The year-to-date summary details your account activity. The following is an explanation of terms used:

Annual Election:	Total yearly amount you elect to contribute to the program
Administrative Fee*:	up to $4.00 monthly, up to $48.00 annually
Benefit Amount:	your annual election less the up to $48.00 annual administrative fee
Claims Submitted:	total amount of all claims submitted
Available Balance:	your benefit amount less the amount of claims paid
Amount Unpaid:	the dollar amount of claims submitted which exceeds the benefit amount
* The annual administrative fee may be adjusted by the FSA Administrator, but will not be greater than $48 per program.	

Quarterly Statement

In addition to the information on your monthly claims payment statement, every calendar year quarter you will also receive a statement detailing all of your account activity, regardless of whether any claims were submitted for reimbursement during the quarter.

The following is an explanation of terms used:

Annual Election:	total yearly amount you elect to contribute to the program
Administrative Fee*:	up to $4.00 monthly, up to $48.00 annually
Benefit Amount:	your annual election less the up to $48.00 annual administrative fee
Amount Reimbursed to Date:	total amount of all claims paid
Available Balance:	your benefit amount less the amount of all claims paid
Deposits:	total amount of contributions to the program in a given month (Note: Activity during the last pay period of the reported quarter may not appear until your next statement.)
Claims Submitted:	total amount of all claims submitted
Claims Paid:	total amount reimbursed to date from your account
Amount Unpaid:	the dollar amount of claims submitted which exceeds the benefit amount
* The annual administrative fee may be adjusted by the FSA Administrator, but will not be greater than $48 per program.	

Note: This instruction sheet was formulated to assist you in the reading of your monthly claims payment and 4 quarterly statements. Please refer to this sheet throughout the Plan Year.

Health Care Flexible Spending Account (HCFSA) Program

Over-the-Counter (OTC) Drug Claims

Please follow these procedures for submitting claims for OTC drugs:

1. Submit your Claims Forms once a month, on or before the last day of the month. (Minimum reimbursement amount requested must total $50.00 unless current account balance is less than $50.00).
2. Attach 3rd Party Receipt (not handwritten or printed by participant or recipient), which includes:
   - Name of drug;
   - Date the drug was purchased; and
   - Amount paid for the drug.
3. In the event that the receipt from the store in which the item was purchased does not specify the information listed in item number 2 above, you must submit, along with your receipt and Claims Form, additional documentation with identifying information that includes all of the information listed in item number 2. For example, you can include a photocopy of the original packaging (i.e., product box) bearing the product's name and/or the price tag on the package. For certain purchases, the Plan Administrator may require further documentation from your physician.
4. Attach copy of doctor's prescription for only sunscreens, vitamin and nutritional supplements.
   Examples of items that are ineligible for reimbursement include:

Over-the-Counter Items That are Eligible		***Over-the-Counter Items That are Eligible with a Prescription or a Letter of Medical Necessity***
Acid controllers	Respiratory treatments	Sunscreens
Anti-itch medicines	Sleep aids	Nutritional supplements
Antihistamines	Bandages	Vitamins
Baby rash ointments/creams	Braces and supports	
Cold sore remedies	Contact lens supplies/solutions	
Cough medicines	First aid supplies	
Digestive aids	Insulin	
Laxatives	Reading glasses	
Menstrual care products	Thermometers	
Motion sickness products	Walkers	
Pain relievers	Wheelchairs	

OTC drugs must be directly related to the diagnosis, cure, mitigation, prevention or treatment of an illness or medical condition.

Note: Not all OTC drugs are eligible for reimbursement. Please refer to the checklist below to see if your purchase qualifies.

Is the purchase considered a drug or medical supply?

If the answer is NO, you will not be reimbursed.
If the answer is YES, answer the remaining questions:

Is the purchase merely beneficial to your general health?

If the answer is YES, you will not be reimbursed.
If the answer is NO, answer the remaining questions:

Is this drug or medical supply necessary for the treatment of disease or for the purposes of affecting any structure or function of the body?

If the answer is YES, you will be reimbursed.
If the answer is NO, answer the remaining questions:

Is this drug or medical supply necessary for the diagnosis or cure of disease or for the purposes of affecting any structure or function of the body?

If the answer is YES, you will be reimbursed.
If the answer is NO, answer the remaining question:

Is this drug or medical supply necessary for the mitigation (improvement) of disease or for the purposes of affecting any structure or function of the body?

If the answer is YES, you will be reimbursed.
If the answer is NO, you will not be reimbursed for this OTC purchase.

Note: This instruction sheet was formulated to assist you in the submission of your claims. Please refer to this sheet through-out the Plan Year.

Reset Fields | Print Form

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.	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 - (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
Medical Necessity Form

Bowling Green Stattion, P.O. Box 707, New York, NY 10274
nyc.gov/fsa

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

HCFSA

Instructions:

Under Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement under the HCFSA Program when your health care provider certifies that they are medically necessary. In these cases, your provider must indicate your (or your spouse's or dependent's) specific diagnosis, specific treatment recommended, the length of treatment, and how this treatment will alleviate your medical condition. Please note that medical care must be for expenses to diagnose, cure, mitigate, treat or prevent disease or to affect any structure or function of the body.

Please give this form to your health care provider so that he or she may provide the required information in order to process your claim. Your provider may also submit a statement on his or her letterhead that includes all the information requested below.

By submitting this form, you certify that the expense you are claiming is a direct result of the medical condition described below, and you would not incur the expense you are claiming if you were not treating this medical condition.

You only need to submit this form, or a letter from your health care provider, with the first claim you submit for the service or product. However, if treatment extends beyond the time period listed, you must submit a form or physician letter covering the new time period. You must submit a new form each year; they cannot be approved indefinitely.

NOTE: **Submitting this form does not guarantee that the expense will be reimbursed. You must also submit all claims to your health insurance carrier(s) before HCFSA can process your claims.**

If you have any questions, please contact the HCFSA Program by e-mail at nyc.gov/fsa

PLAN YEAR: ☐☐☐☐

EMPLOYEE/PATIENT INFORMATION

EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME | M I | SOCIAL SECURITY NUMBER - -

PATIENT LAST NAME | PATIENT FIRST NAME | M I | RELATIONSHIP TO EMPLOYEE

EMPLOYEE SIGNATURE | DATE / /

TO BE COMPLETED BY PROVIDER

☐ I have attached a separate sheet with additional information.

PROVIDER NAME

PROVIDER ADDRESS

CITY | STATE | ZIP + FOUR +

PROVIDER LICENSE NUMBER | PROVIDER TELEPHONE NUMBER (AREA CODE) - - | CPT CODE

DIAGNOSIS

RECOMMENDED TREATMENT

DESCRIBE HOW THE TREATMENT WILL ALLEVIATE THE MEDICAL DIAGNOSIS

LENGTH OF TIME TREATMENT REQUIRED

PROVIDER SIGNATURE | DATE: / /

OFFICE USE ONLY (DO NOT WRITE IN THIS BOX)

REVIEW DATE / /

☐ ACCEPTED
☐ DECLINED

REVIEWED BY

REASON FOR DECLINE

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

Health Care Flexible Spending Account (HCFSA) Program
Health Insurance Portability and Accountability Act (HIPAA) Protected Health Information (PHI) Authorization Form

Bowling Green Station, P.O. Box 707, New York, NY 10274
Tel: (212) 306-7789 nyc.gov/fsa

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

PLEASE READ:

We are unable to speak to anyone other than the participant about personal information or claims unless we have an authorization on file. If you would like to authorize a person to receive private information, please fill out this form. In order for the authorization to be valid, you must sign and fill out the form completely. You must list the specific person(s) or organization(s) you are authorizing in Section II. Also, you must provide a description of the information in Section III. For example, if you would like your spouse/domestic partner to receive information about your medical claims, you must list your spouse/domestic partner in Section II, and write "medical claims information" in Section III. Please return your authorization form to the address above, in care of "HCFSA HIPAA OFFICE", or submit electronically to https://nyc-fsa.leapfile.net

I. *Participant Information*

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER
			- -

HOME ADDRESS NUMBER AND STREET	APT. #

CITY	STATE	ZIP CODE

DATE OF BIRTH	HOME PHONE NUMBER (AREA CODE)	WORK PHONE NUMBER (AREA CODE)	MOBILE PHONE NUMBER (AREA CODE)
/ /	( ) -	( ) -	( ) -

AGENCY NAME

II. *Specific person/organization (or class of persons) authorized to receive and use PHI:*

	LAST NAME	FIRST NAME	RELATION TO PARTICIPANT
1.			
2.			
3.			
4.			
5.			
6.			

III. *Specific description of the information (medical examination reports, Explanation of Benefits, etc.) and the purpose for which it may be used or disclosed (to assist in resolving a claim, at the participant's request, etc.)*

IV. *Acknowledgement and Right to Revoke:*

I authorize the HCFSA Program to use or disclose my individually identifiable health information as outlined above. I understand that I can refuse to sign this authorization and that I can inspect or copy the health information that is used or disclosed in accordance with this authorization. I understand that I have the right to revoke this authorization at any time by notifying the HCFSA Program in writing at Bowling Green Station, P.O. Box 707, New York, NY 10274 or emailing the progam via the FSA website and selecting Email FSA. I understand that the revocation is only effective after it is received and logged into the HCFSA database. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it. I understand that I am entitled to receive a copy of this authorization. I understand that this authorization will expire when my employment with the City terminates.

SIGNATURE	DATE
	/ /

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign this form on the basis of: