



Health Care Flexible Spending Account (HCFSA) Program Claim Form

Please read “Instructions and Important Information” on Page 3 before completing this form and refer to your enrollment information for HCFSA rules and regulations.

Employee (participant) information – All sections must be completed

Last 4 of Social Security Number: _____

Last Name: _____ First Name: _____ MI. _____

Agency Name (Not Division): _____

Mobile Phone Number: _____ Email Address: _____

☐ Check here if this is a new address

Home Address - Number and Street _____

Apt. No. _____ City: _____ State: _____ Zip: _____

Claim 1 – Please complete all sections

Patient Name	First: _____ Last: _____
Date(s) of service	From: _____ To: _____
Types of service (check only one)	☐ Medical ☐ Vision ☐ RX ☐ OTC ☐ Dental ☐ Hearing aid
Plan period (check only one)	☐ 2027 Plan Year (1/1/2027-12/31/2027) ☐ Grace period 2026 (1/1/27 – 03/15/2027)
Reimbursement amount requested	\$ _____
Provider's Information:	

Claim 2

Patient Name	First: _____ Last: _____
Date(s) of service	From: _____ To: _____
Types of service (check only one)	☐ Medical ☐ Vision ☐ RX ☐ OTC ☐ Dental ☐ Hearing aid
Plan period (check only one)	☐ 2027 Plan Year (1/1/2027-12/31/2027) ☐ Grace period (1/1/27 – 03/15/2027)
Reimbursement amount requested	\$ _____
Provider's Information:	

Claim 3

Patient Name	First: _____ Last: _____
Date(s) of service	From: _____ To: _____
Types of service (check only one)	☐ Medical ☐ Vision ☐ RX ☐ OTC ☐ Dental ☐ Hearing aid
Plan period (check only one)	☐ 2027 Plan Year (1/1/2027-12/31/2027) ☐ Grace period (1/1/27 – 03/15/2027)
Reimbursement amount requested	\$ _____
Provider's Information:	

Total Reimbursement Amount Requested (1+2+3): \$ _____

☐ Direct Deposit account update (**Attach Voided Check to this form**)

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?

Forms/documents can be sent via secure upload to: <https://nyc-fsa.leapfile.net>

Please continue below for Instructions and Important Information

Instruction and Important Information - HCFSA

2027 Period	Dates	Activities
Plan year	January 1, 2027, through December 31, 2027	Submit claims for your eligible expenses.
Grace Period	January 1, 2028, through March 15, 2028	You can use any remaining balance in your Plan Year 2027 account.
Claims Run-Out Period	Offered until May 31, 2028	This is the final opportunity to submit reimbursement requests for 2027.

1. When submitting a claim, please indicate if the claim should be applied to Plan year. If you participated in the HCFSA 2026 Plan Year and have a balance, any claims with service incurred by 3/15/2027 will be applied to your balance.
2. 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.
3. 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.
4. If the amount on the HCFSA Claim Form is less than \$50.00, the claim will be held until the total eligible reimbursement amount reaches \$50.00.
5. Payments are issued monthly. Claims must be received by the 15th day of each month to be processed for that month.
6. Is required to attach the Explanation of Benefits (EOB) statement from your health insurance carrier(s) for medical expenses (i.e., deductibles, co-payments). Except when the cost is under \$50.00.
7. Is required to attach the EOB from your Welfare Fund for dental, vision and/or hearing expenses.
8. 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.

9. 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.
10. 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.
11. You may obtain additional claim forms on the FSA website at [nyc.gov/fsa](https://nyc-fsa.leapfile.net).

Submit claims promptly, such as monthly or every few months, to the FSA Program Administrative Office through:

FSA secure upload site: https://nyc-fsa.leapfile.net	Via regular mail to: The Flexible Spending Accounts Program P.O. Box 707 Bowling Green Station New York, NY 10274	Express mail forms may be sent to: NYC Flexible Spending Accounts Program 22 Cortlandt Street, 28th Floor New York, NY 10007
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