

**MEDICAL Flexible Spending Account**  
**Request for Reimbursement**

**FCPS**

**SECTION A: Employee Information** (please print clearly in ALL CAPITAL letters)

**Plan Year: 7.01.10 – 6.30.11**

Name: \_\_\_\_\_ Employee ID: \_\_\_\_\_  
(FIRST NAME LAST NAME) (This may be your SSN or employer assigned number)

Employer: **Frederick County Public Schools**

Email: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Check here if new address

**SECTION B: Claim information and Signature**

**PLEASE READ CAREFULLY:** I certify that the expenses listed below have been incurred by me, my spouse and/or my eligible dependents during the plan year and while I was a participant in the plan. To the best of my knowledge all expenses below are eligible under the plan. I certify that any prescriptions drug expenses are for medical care and not cosmetic purposes. I understand that I am responsible for the accuracy of the information related to this expense. I have not and will not seek to be reimbursed through any other health plan coverage for any of the expenses listed below. I further declare that I will not deduct any of the reimbursed medical expenses listed below from my federal, state or local tax returns.

Total amount of this claim requested: \$ \_\_\_\_\_ Number of pages sent (do NOT fax a cover sheet): \_\_\_\_\_

 Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION C: Medical Claim details** (please print clearly in ALL CAPITAL letters)

- 1) Provider: \_\_\_\_\_ Date of Service: \_\_\_\_\_ Amount: \_\_\_\_\_
- 2) Provider: \_\_\_\_\_ Date of Service: \_\_\_\_\_ Amount: \_\_\_\_\_
- 3) Provider: \_\_\_\_\_ Date of Service: \_\_\_\_\_ Amount: \_\_\_\_\_
- 4) Provider: \_\_\_\_\_ Date of Service: \_\_\_\_\_ Amount: \_\_\_\_\_
- 5) Provider: \_\_\_\_\_ Date of Service: \_\_\_\_\_ Amount: \_\_\_\_\_
- 6) Provider: \_\_\_\_\_ Date of Service: \_\_\_\_\_ Amount: \_\_\_\_\_
- 7) Provider: \_\_\_\_\_ Date of Service: \_\_\_\_\_ Amount: \_\_\_\_\_
- 8) Provider: \_\_\_\_\_ Date of Service: \_\_\_\_\_ Amount: \_\_\_\_\_

TOTAL AMOUNT OF MEDICAL REIMBURSEMENT REQUESTED: \$ \_\_\_\_\_

**FAX THE CLAIM TO:**  
**888-510-4218**

or EMAIL TO:

Claims@hfsbenefits.com

If mailing, please keep the originals for  
your records.

Mailed claims can be sent to:

PO Box 1550

Hunt Valley, MD · 21030-1550



**BEFORE SENDING MAKE SURE YOU ...**

- Complete this form in its entirety. Failure to complete all sections can result in a delay in processing your reimbursement.
- Itemize all expenses on the claim form. List the provider name, date of service (the date the service was INCURRED), and the amount of each expense. Please use additional sheets if necessary. Do NOT indicate 'See attached' or 'Various' in any field.
- Attach proof of expense (invoice, receipt, EOB, etc.) in the order you have them listed above.
- Receipts, invoices, etc. must show the date, type and amount of service/product purchased.
- Circle the date and the amount requested on each receipt. Do NOT highlight.



**BEFORE SENDING MAKE SURE YOU DO NOT...**

- Send in cancelled checks or credit card receipts. These are NOT acceptable.
- Send in a receipt listing 'BALANCE DUE' or 'BALANCE FORWARD'.
- Fax in your claim multiple times.

View your account online at [www.hfsbenefits.com](http://www.hfsbenefits.com)



**DEPENDENT CARE Flexible Spending**  
Account Request for Reimbursement

FCPS

**SECTION A: Employee Information** (please print clearly in ALL CAPITAL letters)

Plan Year: 7.01.10 – 6.30.11

Name: \_\_\_\_\_ Employee ID: \_\_\_\_\_  
(FIRST NAME LAST NAME) (This may be your SSN or employer assigned number)

Employer: **Frederick County Public Schools**

Email: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_  
 Check here if new address

**SECTION B: Claim information and Signature**

**PLEASE READ CAREFULLY:** I certify that the expenses listed below have been incurred by me, my spouse and/or my eligible dependents during the plan year and while I was a participant in the plan. To the best of my knowledge all expenses below are eligible under the plan. I declare that I will not deduct any of the reimbursed Dependent Care expenses listed below from my federal, state or local tax returns.

Total amount of this claim requested: \$ \_\_\_\_\_ Number of pages sent (do NOT fax a cover sheet): \_\_\_\_\_

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION C: Dependent Care Claim details** (please print clearly in ALL CAPITAL letters)

1.	Period of Dependent Care <b>FROM DATE:</b>	<b>To Date:</b>	
	<b>Provider Name:</b>	<b>Age of Dependent:</b>	
	<b>If no receipt is available, please have caregiver sign here:</b>	<b>Amount:</b>	
2.	Period of Dependent Care <b>FROM DATE:</b>	<b>To Date:</b>	
	<b>Provider Name:</b>	<b>Age of Dependent:</b>	
	<b>If no receipt is available, please have caregiver sign here:</b>	<b>Amount:</b>	
3.	Period of Dependent Care <b>FROM DATE:</b>	<b>To Date:</b>	
	<b>Provider Name:</b>	<b>Age of Dependent:</b>	
	<b>If no receipt is available, please have caregiver sign here:</b>	<b>Amount:</b>	

Total Amount for which I am requesting reimbursement: \$ \_\_\_\_\_

<p><b>FAX THE CLAIM TO:</b> <b>888-510-4218</b> or EMAIL TO: Claims@hfsbenefits.com If mailing, please keep the originals for your records. PO Box 1550 · Hunt Valley, MD · 21030-1550</p>	<p><b>STOP BEFORE SENDING MAKE SURE YOU ...</b></p> <ul style="list-style-type: none"> <li>• Complete this form in its entirety. Failure to complete all sections can result in a delay in processing your reimbursement.</li> <li>• Attach proof of expense (receipt, invoice, etc.) If no receipt is available, the caregiver must sign where indicated.</li> <li>• <b>Keep originals</b> for your records.</li> </ul> <p><b>STOP BEFORE SENDING MAKE SURE YOU DO NOT...</b></p> <ul style="list-style-type: none"> <li>• Send in cancelled checks or credit card receipts. These are NOT acceptable.</li> <li>• Fax in your claim multiple times.</li> <li>• Send in Dependent Care Claims prior to services being incurred.</li> </ul>
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View your account online at [www.hfsbenefits.com](http://www.hfsbenefits.com)



## Debit Card Substantiation Form



**Frederick County Public Schools**  
**Plan Year: 7.01.10 - 6.30.11**

<b>Employee First Name</b>	<b>Employee Last Name</b>
<b>Employee ID No.</b> -      -	<b>Daytime Phone #</b>
<b>Home Address</b> <input type="checkbox"/> <b>Check here if new address</b>	
<b>E-Mail Address</b> <input type="checkbox"/> <b>Check here if new address</b>	

This form is to be used to send receipts to verify that pending charges to your Flex Debit card are for eligible expenses. Please note, many of your Flex Debit card charges will automatically be approved by HFS Benefits. Please visit our website, [www.hfsbenefits.com](http://www.hfsbenefits.com), to view the status of your Flex Debit card charges or call our customer service center at 888.460.8005 option 2.

Debit Card Purchases		
Date of Debit Card Transaction	Provider/Vendor	Amount

Substitute Receipt(s)	
<input type="checkbox"/>	Please use the attached substitute receipt(s) for eligible expenses of equal or greater value to satisfy the above transaction. Receipt(s) will only be applied up to the amount of the transaction. Any excess will not be reimbursed or applied to future transactions.

Debit Card receipt substantiation may be submitted by one of the following methods:	
<b>E-Mail:</b> debitcard@hfsbenefits.com	<b>E-Mail Instructions:</b> Scan a completed Debit Card Substantiation Form and receipt and e-mail to HFS Benefits.
<b>Fax:</b> 410.771.5533 888.510.4218	<b>Fax Instructions:</b> Make a copy of the receipt and fax a completed Debit Card Substantiation Form to HFS Benefits.
<b>Mail:</b> HFS Benefits Debit Card Compliance P.O. Box 1550 Hunt Valley, Maryland 21030-1550	<b>Mail Instructions:</b> Mail a completed copy of the Debit Card Substantiation Form and receipt to HFS Benefits

**PLEASE READ CAREFULLY:**

- ✓ Itemize all expenses on this form. List the date of the Flex Card charge, the providers name and the amount of each charge. Please use additional sheets if necessary. Do not indicate ' See attached' or 'Various' in any field.
- ✓ Attach proof of expense (invoice, statement, EOB, etc.) in the order you have them listed above.
- ✓ Statements, invoices or EOBS (if required by the Plan) must include the date, type and amount of service/product purchased
- ✓ Circle the date of the service and the amount of the charge on each receipt. DO NOT highlight on the documentation
- ✓ Credit Card receipts cannot be accepted as receipts.
- ✓ If faxing, DO NOT include a fax cover sheet.
- ✓ If you have inadvertently used your MBI card for an ineligible purchase, please submit a check, payable to your employer for the amount of the transaction. Once we receive the check we will approve the charge and credit the monies back into your account for future use.

**Remember**

- ✓ All charges to your Flex Debit card will be applied to the Plan Year in which the card was swiped. Therefore, do NOT use your Flex Debit Card to pay for expenses incurred outside the current plan year and/or outside a period of coverage. Please note the INCURRED date is the day the service was rendered or the date the item was delivered, not necessarily the date of payment.

**Please return this completed form via Fax, Mail or Email to HFS Benefits**

Fax:  
888.510.4218

Mail:  
PO Box 1550  
Hunt Valley, MD  
21030-1550

Flex Debit Card Email:  
debitcard@hfsbenefits.com