DEPARTMENT OF MANAGEMENT SERVICES

# Claim Form
## for MRA, LPMRA, DCRA and the *my*MRA Card

People First
STATE OF FLORIDA HR
P.O. Box 1800, Tallahassee, FL 32302-1800

**PLEASE READ THE INSTRUCTIONS ON THE BACK BEFORE COMPLETING THIS FORM. KEEP A COPY OF THIS FORM FOR YOUR RECORDS.**
**SEND COPIES OF ORIGINAL RECEIPTS. ATTACH ADDITIONAL FORMS IF NECESSARY.**



**USE ONLY BLACK INK**

## PERSONAL DATA

Name: _____ Home Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

SS#: ___|___|___|___|___|___|___|___|___ Employer: _____ Day Time Phone: _____

Email: _____

## I understand, agree and certify to the following:

- I will use my FSA to pay for only IRS-qualified expenses permitted under my employer's FSA plan(s). These services were provided to my IRS-eligible dependents and/or to me on the date(s) listed below. These expenses were incurred within my period of coverage during the plan year.
- I will request reimbursement only after the services have been provided.
- I have not and will not seek reimbursement through any other source, including any other Flexible Spending Account such as those provided under my employer's plan(s), for these expenses.
- I will collect and maintain sufficient documentation to validate my reimbursed FSA expenses.
- I will not claim any reimbursed FSA expense for any federal income tax deduction or credit.
- I specifically release my employer and People First from any liability resulting from either my participation in any FSA or for any misrepresentation I make regarding my requests for reimbursement.
- If I participate in my employer's Dependent Care FSA plan, I will file a Form 2441 with my income tax return and provide any taxpayer identification number required.
- The dependent care expenses I submit for reimbursement were incurred to allow my spouse (if married) and me to work or actively look for work. My spouse is considered working (i.e., gainfully employed) if he or she is a fulltime student for five months during the calendar year at an educational organization or is physically or mentally incapable of self-care.
- I have read and understand the information on the front and back of this form.

**Participant's Signature:** _____ **Date:** _____
(Required to process claim/reimbursement)

## MEDICAL REIMBURSEMENT ACCOUNT *Place a check mark [✔] in the box(es) and fill in claim amount of any that apply below:*

**A.** ☐ I used the *my*MRA card to pay for these expenses - must attach documentation for transactions requiring documentation.† $_____

**B.** ☐ Please reimburse me for these out-of-pocket expenses - documentation must be attached.† $_____

**C.** ☐ Please apply attached documents as substitution toward card transactions requiring documentation.†
(For lost documentation or substantiation of an ineligible charge) $_____

*Fill out completely.* Use for eligible medical expenses for yourself and your qualifying dependents.

| CHECK (✔) PAYMENT TYPE: A. Card | B. Pay me | C. Sub. docs. | Name of Person Receiving Service | Relationship to Employee | Provider of Services* | SERVICE DATE:** FROM: | TO: | CLAIM AMOUNT |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | $ |
| | | | | | | | | $ |
| | | | | | | | | $ |
| | | | | | | | | $ |
| | | | | | | | | $ |
| | | | | | | TOTAL THIS PAGE | | $ |
| | | | | | | GRAND TOTAL FOR MULTIPLE PAGES | | $ |

## DEPENDENT CARE REIMBURSEMENT ACCOUNT *Fill out completely.* For qualifying childcare, dependent care and elder care services.

| Name of Person Receiving Service | Relationship to Employee | Age and Grade | Name and Address of Persons or Facility Providing Service | SERVICE DATE:** FROM: | TO: | CLAIM AMOUNT |
|---|---|---|---|---|---|---|
| | | | | | | $ |
| | | | | | | $ |
| | | | | | | $ |
| | | | | | TOTAL THIS PAGE | $ |
| | | | | | GRAND TOTAL FOR MULTIPLE PAGES | $ |

**SIGNATURE OF DAY CARE PROVIDER** (LISTED ABOVE)
**OR ATTACH STATEMENT / BILL** : _____

† Please remember to keep copies for your records.
* "Provider of Services" means hospital, doctor, dentist, drugstore, medical supply store, etc.
** "Service date" refers to dates service was PROVIDED or available for pickup, not the date you paid or were charged for it.

**People First Service Center - Flexible Spending Accounts**
Mail to: P.O. Box 1800, Tallahassee, Florida 32302-1800
Toll-Free Fax to: **1-888-800-5217** Tallahassee Fax: **850-425-4608**
Customer Care: 1-866-663-4735; TTY 1-866-221-0268

*If you fax your reimbursement request to People First, retain a copy for your records. Do not mail the copy of your faxed transmittal to People First.*

# IMPORTANT INFORMATION FOR REIMBURSEMENT

**(TO AVOID DELAYS, PLEASE READ THESE INSTRUCTIONS CAREFULLY.)**

**IMPORTANT REQUIREMENTS & INFORMATION** (not following these requirements may cause your claim to be rejected)

- Complete all lines in the Personal Data Section.
- Use black ink only.
- Do not use highlight markers on your claim form or documentation (we scan all documents).
- Submit copies of invoices, statements, bills, receipts, or EOB in the same order as listed on the claim form.
- Credit card receipts and canceled checks cannot be used to approve your claim.
- Account holder must sign and date the claim form.
- More forms are available at **http://myFlorida.com/myBenefits** and on the People First website.
- Attach additional sheet for more items/lines.
- Retain a copy of your claim form(s) and all documentation for your records.

**DOCUMENTATION REQUIREMENTS:**

**Medical Reimbursement Account (MRA)** documentation must include the following:

- Date service(s) were received (not necessarily same as date paid)
- Your cost for the service(s) - total amount that is your responsibility
- Type of service(s) (x-ray, office visit, prescription drug name or over-the-counter item, etc.)
- Name of person receiving services (this must be the account holder, spouse, or IRS eligible dependent)
- An EOB can be submitted in lieu of a statement or bill

**Orthodontics –** The following is required:

- A written statement from the treating dentist/orthodontist showing the type and date the service incurred, the name of the eligible individual receiving the service and the cost for the service and
- A copy of the patient's contract with the dentist/orthodontist for the orthodontia treatment (only required if a participant requests reimbursement for the total program cost spread over a period of time).

**Note:** Reimbursement of the full or initial payment amount may only occur during the plan year in which the braces are first installed.

**Special Requirements –** In addition to the documentation noted above, some services require additional documentation such as a Letter of Medical Need, a Capital Expense Worksheet, or a Personal Use Statement. Please visit **https://peoplefirst.myflorida.com** for forms and instructions.

**Dependent Care Reimbursement Account (DCRA)**

- If the personal data section and the dependent care section are completed in their entirety and the form has been signed by yourself and your day care, no further documentation is needed.
- In lieu of the provider signature, you can submit a statement, invoice or bill that shows the name and address of the provider, beginning and ending dates of the provided services, the cost of service(s), and the name of the eligible dependent(s).
- Claim requests for multiple months will be prorated and itemized based on the number of months listed. Payment will be issued after the end of each month for which services were incurred, based on the available balance in your account.
- Educational expenses incurred for a child in kindergarten and up are not reimbursable. The cost of dependent care before and after school is reimbursable.
- Expenses such as tuition, registration fees, activity fees, books, supplies and meals are not reimbursable.

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Visit **https://peoplefirst.myflorida.com** for frequently asked questions, account balances, documentation requirements for card transactions, and forms.