BALDWIN WHITEHALL SCHOOL DISTRICT

FSA Medical **FSA Dependent Care**

Consumer Profile

Last Name:		First Name:	
Address Line 1:		Address Line 2:	
City:		State, Zip:	
Email Address:		Phone:	

☐Please check if this is a new address.

Claims Details

I hereby file claim for the expenses noted below. I certify that each expense had service rendered on the date and for the person and reason noted and is not reimbursable by insurance. Attached are receipts or other evidence of my having had service rendered for these expenses during the plan year. These expenses are for myself or my dependent that I claim as a dependent on my income tax. I understand that my employer has the right to verify these expenses.

****IMPORTANT NOTE****
CREDIT CARD RECEIPTS AND/OR CANCELLED CHECKS DO NOT QUALIFY AS A VALID RECEIPTS.

Please submit itemized statements from the provider or the Explanation of Benefits (EOB) from your insurance carrier.

Debit Card	Expense Description	Service Date	Patient Name	Provider Name	Amount
☐					
☐					
☐					
☐					
☐					
☐					
☐					
☐					
☐					
☐					

Total FSA Expenses Claimed $ ____________

Claim Certification

Signature: X_____________________________________ Date: ___ ___ / ___ ___ / ___ ___ ___ ___

Please Note: Signature of employee is required for payment from your FSA account.

Corporate Coverage TPA
795 Pine Valley Drive, Suite 21, Pittsburgh, PA 15239 ● www.corporatecoveragetpa.net
Email Address: questions@corporatecoveragetpa.net ● Phone: 866- 403-9378 ● Fax: 866-919-8920