QualCare, Inc.
Flexible Spending Account – HEALTH CARE CLAIM FORM

Submit Claims to:
QualCare, Inc.
PO Box 639
Piscataway, NJ 08855-0639

TOTAL AMOUNT OF REIMBURSEMENT REQUESTED $

Participant Information

Name: _____
Last First MI

Home Address: _____
Street City State Zip

Social Security #: _____-_____-_____

Employer: QualCare, Inc.

Ext. _____

☐ Check if this a change in address

Helpful Hints to Expedite Your Reimbursement

Please follow these simple guidelines when submitting your claims for reimbursement.

- Please list one patient and service per line. The type of service field indicates what type of service was provided, i.e., Medical (Med), Dental (Den), Vision (Vis), Orthodontia (Ort), or Prescription (RX).
- In accordance with IRS regulations, the actual date which services were rendered is required. Many providers and insurance bills have a separate billing date, please don't mistake this billing date for the date services were performed.

Reimbursement Guidelines

In order to receive reimbursement, supporting documentation must be attached to this completed claim form (including expense itemization). Please include an itemized statement from the provider listing dates of service, service performed, charge, and the name of the patient receiving the service. If you have insurance, please submit the corresponding Explanation of Benefits from your insurance company that details their payment and the amount of which you are responsible. If this form is incomplete a letter will be sent to you requesting completion, and processing of your request will be delayed.

	Date Services were Provided MO DA Y YEAR	Name of Provider of Service	Patient Name	Type of Service (Circle One Only Please)	Net Amount
1	____/____/____			Med Den Vis Ort RX	$
2	____/____/____			Med Den Vis Ort RX	$
3	____/____/____			Med Den Vis Ort RX	$
4	____/____/____			Med Den Vis Ort RX	$
5	____/____/____			Med Den Vis Ort RX	$
6	____/____/____			Med Den Vis Ort RX	$

Please read the following and then sign this form.

I certify that all services for which reimbursement is requested under the FSA Plan were incurred by myself or my eligible dependents within the Plan Year of my election, that the expenses associated with these services have been paid by me and that in the case of qualifying medical expenses, they have not been reimbursed or are not reimbursable under any other medical coverage. I will not use qualifying medical expenses reimbursed through my medical reimbursement account or my dependent care reimbursement through my dependent care assistance account as deductions when filing my Federal Income Tax return.

I understand that I am fully responsible for the sufficiency and accuracy of all information relating to medical and dependent care which are provided by me, and that unless expense is a qualifying expense under the FSA, I may be liable for payment of all related taxes and penalties

Signature:_____ Date:_____