CITY OF SAINT PAUL
MEDICAL AND DEPENDENT CARE EXPENSE ACCOUNT
REIMBURSEMENT REQUEST FORM

Name	SS#	**Mail or fax claims to:** Outsource*One* 730 Second Ave. So. - Suite 520 Minneapolis, MN 55402 Phone 612-436-2778 Toll-free 877-491-5979 Toll-free fax: 877-491-6016 Local fax 612-335-9217
Home Address	Address Change Yes No	
City	State / Zip	
Phone: Work Home	e-mail:	

Complete the information below for expenses incurred by you, your spouse, or dependent children for which you request reimbursement. You must provide receipts or other evidence the expenses were incurred. Be sure to provide all information requested on this form. If the form is incomplete it will be returned to you. Print or type the information requested, then sign and date the form. Mail or fax this form and supporting documentation to Outsource*One*.

HCRA
MEDICAL EXPENSES (Medical, Dental, Vision)

	Provider of Service (Doctor, dentist, pharmacy, etc.)	Person Receiving Service (self, spouse, child)	Dates of Service (MO/DAY/YR)	Amount of Expense Claimed	Nature of Expense
1				$	
2				$	
3				$	
4				$	

DCRA
DEPENDENT CARE EXPENSES (if necessary, attached additional sheets)

	Provider of Service	Person Receiving Service (Dependent's name)	Age of Dependent	Dates of Service (MO/DAY/YR)	Amount of Expense Claimed	Provider Tax I.D. Number (Social Security Number if Individual)
1					$	
2					$	
3					$	

Dependent Care Provider's Signature (if individual)____

I request payment from my health care expense or dependent day care expense account as indicated above for the expenses listed. To the best of my knowledge and belief, my statements in this reimbursement request are complete and true. I am claiming reimbursement only for eligible expenses incurred during the plan year and for my eligible dependents. I certify that these expenses have not and will not be reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I authorize my Flexible Spending Account to reimburse me by the amount requested.

Employee Signature____Date____________________

PLEASE SEE REVERSE SIDE FOR FILING INSTRUCTIONS

INSTRUCTIONS FOR COMPLETION OF FLEXIBLE SPENDING CLAIM FORMS

HCRA

HEALTH CARE EXPENSES (Medical, Dental, Vision)

- Complete claim form – all requested information must be provided or claim will be denied.
- Attach originals or copies of medical bills, insurance explanation of benefits, prescription drug receipts, cash register receipts, etc. The documentation must provide the following information or the claim will be denied:
    1. Name of provider of service (doctor, dentist, pharmacy, etc.)
    2. Name of person receiving service (self, spouse, dependent)
    3. Date of service
    4. Explanation of procedure
    5. Cost of procedure less any amounts paid by primary insurance provider
- Mail or fax claim and expense documentation to: OUTSOURCE ONE, INC.
520 Peavey Building
730 Second Ave. So.
Minneapolis, MN 55402
Fax (877) 491-6016
Or 612-335-9217

DCRA

DEPENDENT DAY CARE EXPENSES

- Complete claim form – all requested information must be provided or claims will be denied.
- Attach originals or copies of daycare invoices or payment receipts issued by daycare provider. The documentation must provide the following information or the claim will be denied:
    1. Name of daycare provider
    2. Tax ID number or social security number of provider
    3. Name of dependent receiving daycare service
    4. Dates of service
    5. Cost of service
- Mail or fax claim and expense documentation to: OUTSOURCE ONE, INC.
730 Second Ave. So., Suite 530
Minneapolis, MN 55402
Fax (877) 491-6016
Or (612) 335-9217