# of Pages (including this Claim Form): _____

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fsa@rpgconsultants.com

FSA – MEDICAL CLAIMS FORM

Instructions: Reimbursement are made on approximately the 1st and 16th of every month for claims submitted in the previous 15 days. Please send this completed form with proper documentation to ***RPG Consultants – FSA Department at the address above***. Please keep a copy of all correspondence for your records. Copies of this form are available at www.rpgconsultants.com.

Documentation: You must complete this form (send original) and attach documentation (copies only – keep originals) to ensure timely reimbursement. This form must be signed and dated and you must include:

- Proof of expense (expense type, provider, dates of service, name of patient)
- Proof of payment (cancelled check, credit card slip, month-end credit card statement, "paid in cash" statement indicated below for items under $100.00).
  Credit Card: Attach slip or month-end statement. Check: Indicate check # and include cancelled check front and back. Cash: No receipt needed if under $100 otherwise register receipt.
- Insurance company Explanation of Benefits (EOB), if applicable

Eligible Expenses: Please refer to our website at www.rpgconsultants.com for more information. You may also e-mail us at fsa@rpgconsultants.com with any questions. Your contact information below will be used if there are questions about your claim.

Employee Information:

Name:_________________________ Company Name: _________________________

SS:__________________ Date of Birth:______________ Check one: ______Married _______Single

Address:_________________________ City:________________ State:_____ Zip:________

Home Phone:________________ Work Phone:________________ E-mail:____________________

Date	Patient	Relationship	Provider	Description	Cash/Credit Card/Check	Amount

(Additional expenses should be placed on separate forms. Each form treated as individual claim)

Total Medical Expenses: $___________

I request reimbursement for the attached expenses under the Section 125 Cafeteria Plan established by my company. I certify that I, or my eligible dependents, have incurred these expenses. Furthermore, I declare that these expenses have not been reimbursed from any other source nor do I expect them to be. I certify that these expenses are for medical expenses as defined by Section 213 of the Internal Revenue Code.

Signature: ____ Date: ______________________

For Official Use Only: Date Received: __________ Date Processed: _________ Processed By: ________________________ rev. 4/2015