NEW YORK STATE | **Flex Spending Account**

HEALTH CARE SPENDING ACCOUNT

How to File a Claim for Approval

Claim Filing Options:

- **File claim online:** Log in to your account at **participant.wageworks.com/NYSFSA** to submit your claim electronically.
- **File claim via fax or mail:** Claim details may be entered online and a completed form may be printed and faxed or mailed with documentation. **Fax:** 866-672-3625, **US Mail:** CLAIMS ADMINISTRATOR, P.O. Box 14053, Lexington, KY, 40512

Instructions to fill out this form:

- Complete ALL account holder information.
- Use your documentation to complete each section of the form, including the following:
  - Provider Name
  - Service Date(s)
  - Patient Name and Relationship to Account Holder
  - Type of Service
  - Out-of-Pocket Cost

Tips for Claim Submission

- Reimbursement cannot be claimed if the cost has been or can be reimbursed under any other source.
- Services must have been incurred to receive reimbursement. You may not request reimbursement until you have received the service, regardless of when you pay for it.
- The expenses for which you receive reimbursement cannot be claimed on your income tax return.
- According to IRS regulation, any unused year-end balance in your spending account may not be carried over to the next Plan Year. It will be forfeited to New York State as your employer.
- Mail or fax the completed form to WageWorks and keep a copy for your records.
- The standard mileage rate reimbursable for use of an automobile to obtain medical care is subject to change by the IRS annually. Visit the Flex Spending Account website at www.flexspend.ny.gov for the current rate. Your request for mileage reimbursement must include documentation (such as a receipt from a doctor's office) to verify that the travel is related to medically necessary treatment.

Tips for Documentation

- To request health care expense reimbursement, a copy of your statement, bill or receipt from your health care service provider(s) showing the services received must be submitted with this form. This statement must clearly identify the patient's name, service provider's name and address, date and type of service provided, and amount of expense. For reimbursement of prescription drug costs, your receipt must also include the prescription name and number. OTC drugs require a written prescription in order to be reimbursed.
- At the beginning of the Plan Year in which you seek reimbursement for orthodontia expenses, you must submit a copy of the service contract between you and the orthodontist describing the payment arrangement/schedule.
- Copies of cancelled checks or charge card receipts are not sufficient documentation of incurred expenses.
- Submit legible photocopies of your original statements, bills or receipts, and retain the originals for your records. Do not highlight any portion of the receipts or statements, as it may make the documents illegible and result in your claim being rejected.
- Expenses for cosmetic services and procedures, and items that have a personal, living or family use are ineligible for reimbursement through the HCSAccount. The health care services must promote the proper function of the body or must be designed to treat, prevent, cure or mitigate a specific medical condition as defined by IRS regulations. A letter from your health care provider indicating the services are medically necessary must be submitted with the request for reimbursement of services that are generally considered cosmetic, personal, living or family in nature.

Period of Coverage

- Reimbursement can only be made for expenses resulting from medically necessary services that have been provided within your period of coverage. Your period of coverage is January 1 through December 31 if you enroll during the open enrollment period. If you enroll during the Plan Year as a new hire, your period of coverage begins on the 61st consecutive calendar day of your employment. If you enroll during the Plan Year due to a change in status, your period of coverage will be based on the date your CIS request is received by the Plan. If you terminate employment or take an unpaid leave of absence during the Plan Year, your period of coverage will end once you leave the payroll and stop contributing to your account.
- If a service (such as orthodontia) is provided during your current period of coverage and will continue to be provided in a subsequent Plan Year, you will not receive reimbursement for the services you receive in that subsequent Plan Year unless you re-enroll in the HCSAccount and submit a claim for that period of coverage. For services that require a letter of medical necessity, a new letter from your health care provider indicating the services are medically necessary must be submitted with your claim in the subsequent Plan Year.
- If dates of service begin in one Plan Year and end in the next Plan Year, and you are enrolled for both years, please prorate the expenses and complete a separate form for each Plan Year.
- New York State allows a runout period to submit claims after the Plan Year ends, during which you may submit claims for services that were received during your period of coverage. The runout deadline is March 31 of the following calendar year.

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Pay Me Back Claim Form

- **File claim online:** Join the growing majority of participants who submit their claim online for faster service. Log in to your account at **participant.wageworks.com/NYSFSA** to file your claim electronically and upload your documentation.
- **File claim via fax or mail:** Claim forms may also be filed either via fax or US Mail and sent to the following locations: **Fax:** 866-672-3625.
  US Mail: CLAIMS ADMINISTRATOR, P.O. Box 14053, Lexington, KY, 40512
- **Claim status:** You may check the status of your claim by logging in to your account at **participant.wageworks.com/NYSFSA**.

Employer: NEW YORK STATE FLEX SPENDING ACCOUNT **WW ER ID: 45203**

ACCOUNT HOLDER:

Last Name

First Name

NYS EMPLID

Zip Code

PROVIDER NAME	SERVICE DATES (Start and End Dates) (MM/DD/YY)	PATIENT NAME, RELATIONSHIP TO ACCOUNT HOLDER AND TYPE OF SERVICE	OUT-OF-POCKET COST
		Patient Name: ______ Relationship to Account Holder: ☐ Self ☐ Spouse ☐ Qualifying Child ☐ Qualifying Relative ☐ Other: ______ Type of Service: ☐ Rx ☐ Dental ☐ Psych/Therapy ☐ Ortho ☐ Chiro ☐ Co-payment ☐ Other ______ ☐ Lab ☐ Vision ☐ Hospital ☐ X-Ray ☐ OTC ☐ Office Visit	$
		Patient Name: ______ Relationship to Account Holder: ☐ Self ☐ Spouse ☐ Qualifying Child ☐ Qualifying Relative ☐ Other: ______ Type of Service: ☐ Rx ☐ Dental ☐ Psych/Therapy ☐ Ortho ☐ Chiro ☐ Co-payment ☐ Other ______ ☐ Lab ☐ Vision ☐ Hospital ☐ X-Ray ☐ OTC ☐ Office Visit	$
		Patient Name: ______ Relationship to Account Holder: ☐ Self ☐ Spouse ☐ Qualifying Child ☐ Qualifying Relative ☐ Other: ______ Type of Service: ☐ Rx ☐ Dental ☐ Psych/Therapy ☐ Ortho ☐ Chiro ☐ Co-payment ☐ Other ______ ☐ Lab ☐ Vision ☐ Hospital ☐ X-Ray ☐ OTC ☐ Office Visit	$
		Patient Name: ______ Relationship to Account Holder: ☐ Self ☐ Spouse ☐ Qualifying Child ☐ Qualifying Relative ☐ Other: ______ Type of Service: ☐ Rx ☐ Dental ☐ Psych/Therapy ☐ Ortho ☐ Chiro ☐ Co-payment ☐ Other ______ ☐ Lab ☐ Vision ☐ Hospital ☐ X-Ray ☐ OTC ☐ Office Visit	$

More expenses? Please complete another form.

CLAIM FORM TOTAL: $ 0

CERTIFICATION AND AUTHORIZATION: I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible deductible expenses incurred by myself or an eligible dependent while I was a participant in the plan. (Patient & Relationship is assumed to be Self unless otherwise indicated.) I have already received these products and services and confirm that by requesting reimbursement here that I have not and will not seek reimbursement of this expense from any other plan or party. If I am covered under more than one healthcare account, reimbursement will be made according to the payment order determined by those plans and as stated on the website. Use of this service indicates my acceptance of the WageWorks User Agreement at participant.wageworks.com/NYSFSA (available upon registration; enter username and password or click on Employee Registration link).