Diocese of Yakima—46270
FSA Account Reimbursement Request Form

Employee Name: Last ______________________ First ______________ MI _____ Soc. Sec. ____/____/____

Employee mailing address: ______________________________ City ______________ State ____ Zip: __________

Please check here if this is a change in address ☐ **Email address:** ______________________________

Home Phone: __________________ Work Phone: __________________ Birth Date: _____/_____/_____

Health Care Request

- In order for your reimbursement to be processed timely, you must include with this form the following information:

  A detailed invoice from the provider and/or an insurance company explanation of benefits (EOB) that shows the providers name, patients name, incurred date of service, amount billed, and all amounts paid by your primary and secondary insurance.
- **Please do not staple any documentation to this reimbursement form. It is requested that you tape to a separate sheet or include loosely in your envelope. You should not send originals because all reimbursements are stored electronically and paper copies will be shredded).**

Incurred Date	Provider	Patient	Amount
			$
			$
			$
			$
			$
			$
			$
			$

Dependent Care Request

- You must attach a copy of the provider's bill or a receipt verifying the names and birthdates of the children receiving care, the name of the care provider, the provider's Tax ID or Social Security Number and signature, the date(s) of service and cost, for ALL requests, to this form.

Incurred Dates	Provider	Child(ren)	Amount
From______To______			$
From______To______			$
From______To______			$

To the best of my knowledge and belief, my statements on this reimbursement request form are complete and true. I understand that I am solely responsible for the validity of claims submitted to my Diocese of Yakima FSA Accounts. I am claiming reimbursement only for eligible expenses incurred by me and my eligible tax dependents during the Current Plan Year and any grace period (if applicable) and certify that these expenses have not been reimbursed under this plan or by any other source and that they are not eligible to be reimbursed by any other source or insurance. By providing my email address, I am authorizing that all possible communications regarding this claim may be sent via email. I hereby authorize my Diocese of Yakima FSA Accounts to be reduced by the amount(s) shown above.

Employee Signature ________________________________ ***Date*** __________________

Mail forms and substantiation to: TPSC—Attn: FSA/HRA, P.O. BOX 1894, Tacoma, WA 98401-1894
Fax completed form and substantiation to: (253) 564-5881
Submit completed form and substantiation by visiting tpscbenefits.com and clicking Login, then click Inquiry tab and select Online Forms
Contact TPSC Customer Service: 253-564-5611, Ext. 210 or toll-free 1-800-426-9786, Ext. 210

Qualifying Expenses for the Health Care FSA

The Diocese of Yakima health flexible spending account document contains the rules governing what expenses are and are not reimbursable. Below are some examples to give you a general idea of what items are and are not reimbursable. Please contact TPSC, the Contract Administrator, at (253) 564-5611, Ext. 210 if you have any questions about whether a particular expense is reimbursable.

Examples of expenses for which you may be able to receive reimbursement include:

- Acupuncture.
- Chiropractics.
- Deductibles and co-payments that you are responsible for under our primary medical plan, or under any other medical or dental plan, unless excluded below.
- Eye exams, eyeglasses, contact lenses, and other vision expenses.
- Hearing exams, hearing aids, other hearing expenses.
- Orthodontic and dental expenses (unless cosmetic, e.g., teeth whitening).
- Out-of-pocket medical and dental expenses incurred during the plan year and as defined in Code § 213, unless excluded by the Plan.
- Over-the-counter (OTC) items that ARE NOT considered medicines or drugs.
- Payments to a treatment center for alcoholism.
- Physical therapy.
- Prescribed drugs and medicines.
- Stop-smoking programs.

Exclusions:
The following expenses are not reimbursable:

- Automobile insurance premiums.
- Bottled water.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease. "Cosmetic surgery" means any procedure or drug which is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease

Exclusions (continued):

- Cosmetics, toiletries, toothpaste, etc.
- Costs for sending a problem child to a special school for benefits the child may receive from the course of study and disciplinary methods.
- Custodial Care.
- Diaper service or diapers.
- Funeral and burial expenses.
- Health club or fitness program dues.
- Health insurance premiums that you or your spouse pay for coverage under another health plan.
- Home or automobile improvements.
- Household and domestic help (even though recommended by a qualified physician due to an employee's or dependent's inability to perform physical housework).
- Long-term care services.
- Marijuana and other controlled substances, even if prescribed.
- Maternity clothes.
- Most vitamins and food supplements, even if prescribed.
- Over-the-counter (OTC) items that ARE considered medicines or drugs, without a "prescription".
- Salary expense of a nurse to care for a healthy newborn at home
- Social activities, such as dance lessons (even though recommended by a qualified physician for general health improvement)
- Uniforms or special clothing, such as maternity clothing.

Certificate of Qualifying Dependent Care Expenses

By signing and submitting this Dependent Care Reimbursement Request Form, you are certifying that expenses for which you request reimbursement meet *all* of the following conditions:

- The expenses are incurred for services rendered after the date of your election to receive dependent care assistance benefits and during the plan year to which the election applies.
- The expenses are incurred so you (and your spouse, if you are married) can work or look for work. Exception: If your spouse is not working or looking for work when the expenses are incurred, you certify that he or she is a full-time student or is physically or mentally incapable of self-care.
- The amount of the reimbursement requested, when aggregated with all other reimbursements received by you under the Plan during the same calendar year, do not exceed the lesser of (a) your earned income; or (b) if you are married, your spouse's actual or deemed earned income (see below). (Your spouse is deemed to have monthly earned income of $200 ($400 if you are incurring dependent care expenses for more than one dependent), if your spouse either is a full-time student or is physically or mentally incapable of self-care.)
- Each dependent for whom you incur the expense is (a) a person under age 13 for whom you are entitled to claim a dependency exemption on your federal income tax return (if you are a divorced parent, a child is your dependent if you have custody of the child, even if not entitled to claim the dependency exemption), or (b) your spouse or a person who is your dependent under federal tax law (even if you may not claim the dependency exemption on your federal income tax return), but only if he or she is physically or mentally incapable of self-care.
- You (or you and your spouse together) are providing at least 50% of the cost of maintaining your household, and the expenses are incurred when at least one member of your household is a person described in 4(a) or 4(b) above.
- The expenses are incurred for the care of a dependent, or for related incidental household services.
- If the expenses are incurred for services outside your household, they are incurred for the care of a dependent who is described in 4(a) above (or who is described in 4(b) above and regularly spends at least eight hours per day in your household).
- If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.
- The person who provided care was not your spouse or a person whom you can claim as a tax dependent. If your child provided the care, he or she must be age 19 or older at the end of the year in which the expenses are incurred.
- The expenses are not paid for services outside your household at a camp where the dependent stays overnight.