



# NORTHERN ILLINOIS HEALTH PLAN

## FLEXIBLE SPENDING ACCOUNT CLAIM FORM & FILING INSTRUCTIONS

On the reverse side of this page is a claim form. Please feel free to copy this from.

Mail / Fax / Email / Deliver requests for reimbursements to:  
Mailing Address: PO Box 880, Freeport, IL 61032  
Fax: (815) 599-7059  
E-Mail: [NIHPCustomerservice@nihp.com](mailto:NIHPCustomerservice@nihp.com)

After you fax a request and receipts, please do not follow-up with a hard copy in the mail. *(Please remember to keep a copy of the claim form and supporting documents for your records).*

When filing your claim, you must attach copies of the receipts. According to the Internal Revenue Code, the Flexible Spending Account may reimburse an expense if the participant provides:

- A written statement, receipt or bill from an independent third party stating the expense(s) has been incurred;
- The amount of such expense(s);
- A signed statement that the expense has not been reimbursed or is not reimbursable under any other health plan coverage or a Flexible Spending Account.

\*Please note that it is **your** responsibility to provide support for this claim in the event of an audit by the IRS.

### **Procedures for submitting claims that will help to ensure prompt and efficient processing:**

- Date of service,
- Description of services provided,
- Patient name,
- Provider name and address,
- Total amount of payment for which you are seeking reimbursement,
- An Explanation of Benefits (EOB) from an insurance company, if applicable, must also be submitted.
- Over the counter drugs and items must have a receipt that contains the date purchased, name and cost of item. If the receipt does not provide a name, then a box top or box side should be submitted that contains the name and cost of item that corresponds to the receipt.

**YOU MUST SIGN AND DATE THE CLAIM FORM WHEN SUBMITTING FOR REIMBURSEMENT.**



NORTHERN ILLINOIS  
HEALTH PLAN

FLEXIBLE SPENDING ACCOUNT – CLAIM FORM  
Freeport School District

EMPLOYEE NAME: \_\_\_\_\_ EMPLOYEE SSN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

THIS IS A CHANGE OF ADDRESS / NEW ADDRESS:  YES  NO

MEDICAL/DENTAL/VISION EXPENSES - ATTACH BILLS, RECEIPTS, OR EOB  
TO CLAIM FORM

Item	Patient Name	Date (s) of Service	Provider (Person or Business)	Reimbursement Required
1				
2				
3				
4				
5				

DEPENDENT (CHILD/ELDER CARE) EXPENSES – ATTACH BILLS  
OR RECEIPTS TO CLAIM FORM

Item	Dependent Name	Date (s) of Service	Provider (Person or Business)	Reimbursement Required
1				
2				
3				

**\*Dependent Care Expenses** – If the amount of the above expenses exceeds the balance in your account, *do not* resubmit for the unreimbursed portion on this claim. You will automatically be reimbursed as your account balance allows.

I hereby certify that:

- The information given on this reimbursement form is complete and accurate.
- I have not previously received reimbursement for these expenses from this Flex account or any other source.
- The total of reimbursed dependent care expenses does not exceed the lesser of my spouses or my earned income (W-2 Pay) for the year, if less than \$5,000.
- All health and dependent care expenses listed above comply with the requirements and guidelines listed in the Flexible Spending Reimbursement guidelines and meet the definition of a medical expense as defined in Code Section 213 and ruling and Treasury Regulations thereunder.

Employee Signature\* \_\_\_\_\_

Date\* \_\_\_\_\_

\*Note: Form must be signed and dated in order to process this claim. MINIMUM CHECK AMOUNT \$20.00

\*\*KEEP A COPY FOR YOUR FILES \*\*

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