Custom Design Benefits

FSA CLAIM FORM

(Flexible Spending Account)

Submit Claims To:
Custom Design Benefits, Inc.
5589 Cheviot Road
Cincinnati, Ohio 45247
Ph: (800) 598-2929
Fax: (513) 598-2901
CustomFlex@CustomDesignBenefits.com

Employer:_____

Employee Name: _____Employee or Social Security #: _____

☐Check here if new address Address:_____

City:_____ State: _____Zip:_____ Date of Birth:_____

Email: _____ Phone: _____

IMPORTANT!

When using the FSA Card, please do NOT mail anything in unless requested to do so. Most items will be automatically approved. Please keep copies for your records.

CHANGES FOR OVER-THE-COUNTER MEDICATIONS

Due to Health Care Reform any Over the Counter medications require a prescription from your physician. Prescriptions are valid for **1 Year from the date they are written**. Prescriptions submitted will be kept on file for faster claims processing, and will not need to be submitted again until the prescription has expired.

DEPENDENT CARE REIMBURSEMENT

Name and Date of Birth of Dependent(s)	Period Covered From	To	Name, Address & Taxpayer Identification Number of Service Provider	Claim Amount
Provider's Signature (required if not on receipt):			**Total Dependent Care Claims**	

TO ENSURE WE CAN PROCESS YOUR CLAIM: Provide **proper supporting documentation**, including copies of bills indicating name of provider, name of patient, service/product provided, date the service was provided and amount of the expense not covered by other insurance. Please note: credit card statements do not contain enough info for submitting claims.

HEALTH CARE REIMBURSEMENT For expenses not paid using the *Take Care* FSA Card

Patient Name and Relationship	Date of Service From	To	Name of Service Provider and Description of Expense	Claim Amount
			Total Health Care Claims	

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Flexible Spending Benefit Plan with respect to such expenses and that the health expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the validity and accuracy of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense. Please do not include original receipts, since, after the claim is substantiated, your receipts may not be readily accessible. **Claims will not be processed unless all above information is completed.**

_____ _____

Employee Signature Date

To view claims and other account information visit www.CustomDesignBenefits.com and click *'Custom Flex Login'*