



PO Box 1528, Idaho Falls, ID 83403-1528
 Tele 208.529.4060 Toll Free 800.522.4060
 Fax 208.529.0517

NAME OF EMPLOYEE	SOCIAL SECURITY NUMBER	NAME OF EMPLOYER	
HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	E-MAIL ADDRESS	
STREET ADDRESS (only required if address has changed)		CITY	STATE ZIP CODE

PLEASE SIGN BELOW:

I certify that these expenses are not reimbursable under any other benefit program and will not be claimed as an income tax deduction. I am requesting reimbursement only for qualifying expenses incurred during the Plan Year for eligible Plan participants. Dependent care expenses do not exceed the lesser of my or my spouse's earned income. I authorize my Flexible Spending account(s) to be reduced by the amount(s) requested.

X _____ DATE _____

MEDICAL / DENTAL

SERVICE DATE	NAME OF PATIENT	DESCRIPTION OF SERVICE PROVIDED	CHARGE
			\$
			\$
			\$
			\$
			\$
			\$
			\$
			\$
			\$
TOTAL			\$

CHILD / DEPENDENT CARE

SERVICE DATE	NAME OF DEPENDENT	NAME AND SOCIAL SECURITY NUMBER OF INDIVIDUAL PROVIDING DEPENDENT CARE	CHARGE
			\$
			\$
			\$
TOTAL			\$

OTHER INSURANCE

REIMBURSEMENT CALCULATION	TYPE OF INSURANCE
ANNUAL PREMIUM ÷ PAY PERIODS / YEAR = PAY PERIOD DEDUCTION	MONTHLY PREMIUM
\$ _____ ÷ _____ = \$ _____	

INSTRUCTIONS ON THE REVERSE SIDE

GENERAL INSTRUCTIONS:

- A FSA Claim Form must be submitted with each request for reimbursement.
- Expenses paid by your HRA or FSA cannot be claimed as an income tax deduction.
- Claims need to be received by our office Mondays by 3pm to be in the next days disbursements.
- **When mailing in a claim DO NOT send in original receipts only copies.**

MEDICAL and DENTAL INSTRUCTIONS:

- The expenditure must be for a condition, diagnosed and treatment recommended by a practitioner of the healing arts.
- Attach a copy of the Explanation of Benefits or denial letter from your employee benefit plan.
- If the expenses are for services excluded from your medical/dental plan coverage, also attach a copy of the itemized bills.
- Please list out by date all expenses and prescriptions, DO NOT total them up by year or month.
- **Cancelled checks, balance due statements, and credit card receipts are not acceptable.**

CHILD/DEPENDENT CARE INSTRUCTIONS:

- Attach an invoice for payments to a day-care center or to an individual who provides the care each time a claim is made.
- Please include the social security number or Tax ID number of the provider.
- If the provider takes care of more than six children (not counting their own) he/she must be licensed by the State to qualify for FSA reimbursement.
- The individual who provides the care cannot be your spouse, or child under the age of 19.
- Expenses claimed cannot exceed your spouse's income.
- **Cancelled checks, balance due statements, and credit card receipts are not acceptable.**

OTHER INSURANCE INSTRUCTIONS:

- To qualify for "other insurance" reimbursements, the policy must be an individually owned health, dental or disability policy. Policies that build cash value or a spouse's employer sponsored premiums are not reimbursable.
- For "other insurance", attach a copy of the billing showing the monthly premium.

SUBMITTING YOUR CLAIM:

- Send this Claim Form and any necessary attachments to:
MICA Benefits
PO Box 1528
Idaho Falls, ID 83403
- You may fax your Claim Form and any necessary attachments to:
MICA Benefits
208-529-0517

QUESTIONS, COMMENTS, CONCERNS, IDEAS FOR IMPROVEMENTS:

- Call MICA Benefits Customer Service at 208.529.4060 or 800.522.4060
- E-mail MICA Benefits at claimsadmin@micabenefits.com.

Please visit our website at www.micabenefits.com