

CPA, INC.
420 Washington Street, Suite 100
Braintree, MA 02184
(781) 848-8477 (Fax)

FSA - CLAIM VOUCHER

Address change

Go to www.cpa125.com for additional forms/information

EMPLOYER: _____

EMPLOYEE: _____ SS#: XXX-XX-_____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ PHONE: () _____

E-MAIL ADDRESS: _____

UNREIMBURSED MEDICAL EXPENSES (Participants & Eligible Dependents -as defined by the IRS guidelines)

ITEMS (group similar items)	DATE OF SERVICE	AMOUNT
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
	TOTAL:	\$ _____

DEPENDENT/CHILD CARE EXPENSES (daycare)

_____ \$ _____

OTHER ACCOUNT EXPENSES (e.g. COBRA)

_____ \$ _____

TRANSPORTATION ACCOUNT EXPENSES (For Participants Enrolled in Qualified Parking/Transit Plan ONLY)

PARKING (IRS Monthly max \$230) _____ \$ _____

TRANSIT (IRS Monthly max \$230) _____ \$ _____

All medical claims submitted require copies of bills/statements/receipts showing date and type of service. (No cancelled checks/credit card receipts). All claims must be received 2 days prior to claim payment day. Direct deposit payments are processed weekly (Wednesday). Checks are processed at least twice a month (every other Wednesday). Please allow 3 business days to receive your check. Minimum payment is \$20.00.

This is to certify that I have incurred the expenses listed above that qualify for reimbursement under my employer's Cafeteria Plan. I have not been reimbursed from any other source including insurance programs or other programs offered by my employer. None of these expenses have previously been submitted. I understand and agree that since these expenses are to be reimbursed they may not be claimed as deductions for income tax purposes. Additionally, I am aware that unused funds may be forfeited or otherwise handled in accordance with the plan document and the current IRS law. I hereby request reimbursement for these claims.

PARTICIPANT'S SIGNATURE: _____ DATE: _____

CLAIM PROCESSING & PROCEDURES

- PAYMENTS: DIRECT DEPOSIT PAYMENTS ARE PROCESSED WEEKLY (WEDNESDAY). PLEASE ALLOW TWO BUSINESS DAYS FOR FUNDS TO BE IN YOUR ACCOUNT.


CHECKS ARE ISSUED AT LEAST TWICE A MONTH (EVERY OTHER WEDNESDAY).
- CLAIMS MUST BE RECEIVED **AT LEAST 2 DAYS PRIOR** TO THE SCHEDULED PAYMENT DAY TO BE INCLUDED FOR PAYMENT.
- MEDICAL CLAIMS SUBMITTED REQUIRE COPIES OF BILLS/STATEMENTS/RECEIPTS SHOWING DATE AND TYPE OF SERVICE. (NO CANCELLED CHECKS/CREDIT CARD RECEIPTS).
- YOU MAY FAX A CLAIM AND YOUR RECEIPTS TO CPA, INC. PLEASE LIMIT TO 10 PAGES.
- ELIGIBLE EXPENSES REQUIRE THE DATE OF SERVICE FALL WITHIN YOUR PLAN YEAR, NOT WHEN YOU WERE BILLED OR PAID THE EXPENSE.
- GROUP EXPENSES TOGETHER ON ONE LINE (See Example Below)

<u>ITEMS</u>	<u>DATE INCURRED</u>	<u>AMOUNT</u>
Co-pays	1/6/10 – 5/31/10	200.00
Dental Expenses	2/28/10 – 3/15/10	750.00

IRS Reimbursable Expenses (examples). Please call CPA, Inc. if any questions.

- | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> Acupuncture Alcohol/Drug Therapy Birth Control Pills Braces (Orthodontics) Chiropractors Co-payments for Doctor, Dental Contact Lenses and Solution Dental Fees – <u>No bleaching or veneers</u> Dentures Eye Exams and Glasses Eye Surgery (Laser) Handicapped/Hearing Impaired/Sight Impaired/Learning Disabled Hearing Aids and Batteries Hospital Care/Services Insulin and Testing Supplies | <ul style="list-style-type: none"> Medications Mileage traveled to/from a medical facility:
(16.5 cents per mile effective 1/1/2010) Nursing Services Orthopedic Shoes Osteopath Over-the-counter <u>Medicines</u> Prescriptions Psychologist Fees Psychiatric Care Physical Therapy Surgical Fees Therapy (Physical and Occupational) Viagra |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

***IMPORTANT NOTE: Due to new Health Care Reform, Over-The-Counter items are no longer eligible expenses, effective 1/1/2011.**

 **The following items require a physician prescription each plan year stating the expense is necessary to treat a particular medical condition/disease. Wellness procedures and programs are NOT covered.**

- | | |
|-----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> Health Club memberships Muscular Therapy | <ul style="list-style-type: none"> Weight Loss Programs (No Food) Vitamins/Supplements |
|-----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|