CROWN
BENEFITS ADMINISTRATION

phone: 888.828.5040 / fax: 724.463.5944
Laurel Place, 922 Philadelphia Street, Indiana, PA 15701

Flexible Spending Account Reimbursement Request Form

(INSTRUCTIONS ON REVERSE SIDE)

TO BE COMPLETED BY EMPLOYEE

SECTION I: EMPLOYEE INFORMATION

LAST 4 DIGITS OF EMPLOYEE SOCIAL SECURITY NO	EMPLOYER	PLAN
X X X - X X -	Sharpsville Area School District	FLEXIBLE BENEFITS PLAN

EMPLOYEE'S NAME (Last)	(First)	(MI)

EMPLOYEE'S ADDRESS (Street)

☐ PLEASE CHECK IF NEW ADDRESS

(City)	(State)	(Zip Code)	EMPLOYEE'S PHONE NUMBER
			( )

SECTION II: HEALTH CARE EXPENSES - *Please attach proof of expense incurred*

DATE OF SERVICE	EXPLANATION OF EXPENSE	PATIENT NAME	RELATIONSHIP	AMOUNT OF EXPENSE
				$
				$
				$
				$
				$
				$

SECTION III: DEPENDENT CARE EXPENSES - *Please attach proof of expense incurred*

DATE OF SERVICE FROM	TO	DEPENDENT NAME	DEPENDENT AGE	AMOUNT OF EXPENSE
				$

DEPENDENT CARE PROVIDER NAME	PROVIDER TAX ID NO. OR SOCIAL SECURITY NO.

PROVIDER ADDRESS

DATE OF SERVICE FROM	TO	DEPENDENT NAME	DEPENDENT AGE	AMOUNT OF EXPENSE
				$

DEPENDENT CARE PROVIDER NAME	PROVIDER TAX ID NO. OR SOCIAL SECURITY NO.

PROVIDER ADDRESS

I certify that all expenses, for which reimbursement or payment is requested, were incurred by me (and/or my eligible spouse or eligible dependents) while covered under the Plan; that such expenses have not been reimbursed, or are not reimbursable under any other benefit plan coverage; that such expenses will not be used to claim any federal income tax deduction or credit; and that any over-the-counter item purchased was primarily for medical care. To the best of my knowledge, the information that I have provided on this form is true and complete.

EMPLOYEE'S SIGNATURE _____ DATE _____

CLAIM FILING INSTRUCTIONS

Complete all of the information on the reverse side for Health Care and Dependent Care Expenses incurred by you, your Spouse, or your other eligible Dependents. Failure to complete all areas can result in a delay in processing and claim reimbursement. Incomplete claim forms will be returned.

1. Section I: Employee Information

Please fill out your social security number, full name, home address and home phone number. It is important that we have some means of contacting you in case we need to discuss issues pertaining to your claim for reimbursement.

2. Section II: Health Care Expenses

- Please complete the following information under the Health Care section:
  - **Date of Service/Purchase** - provide the date(s) when the service was provided or the purchase was made. Billing dates do not qualify as service dates. The date must indicate the date the service was received not when it was paid.
  - **Explanation of Expense** - give a brief description of the service provided or the purchase made.
  - **Patient Name** - list the name of the person for whom the service was rendered or for whom the purchase was made.
  - **Patient's Relationship to the Employee** - list whether the patient is a spouse or child.
  - **Amount of Expense -** indicate the amount of the expense which is eligible for reimbursement.
- You must also provide proof of expense such as insurance EOBs, itemized bills/statements or receipts that include:
  - Date of service/purchase
  - Explanation of service/purchase
  - Patient's full name
  - Amount charged for each service/purchase

3. Section III: Dependent Care Expenses

- Please complete the following information under the Dependent Care section:
  - **Date of Service** - provide the dates from which the service was provided.
  - **Dependent Name** - list the name of the dependent for whom the service was rendered.
  - **Dependent Age** - list the age of the dependent for whom the service was rendered.
  - **Amount of Expense** - indicate the amount of the expense which is eligible for reimbursement.
  - **Dependent Care Provider Name** - provide the name of the company or individual who has provided the service.
  - **Provider Tax ID Number or Social Security Number** - provide either number for the company or individual who has provided the service.
  - **Provider Address** - provide the address of the company or individual who has provided the service.
  - You must also provide proof of expense such as itemized bills/statements or receipts that include:
    - Date of service
    - Explanation of service
    - Dependent's name
    - Amount charged for each service

4. Employee's Signature

- This authorizes that you are requesting the expenses to be reimbursed and certifies that your statements on the form are true and complete.

5. Mail or fax completed claim form with all attached EOBs, itemized bills/statements, and receipts to the third party administrator at the address below:

Crown Benefits Administration, Inc.
TPA Services (for SASD)
Laurel Place, 922 Philadelphia Street
Indiana, PA 15701

Fax Number: 724-463-5944

For Questions Please Contact: (888) 828-5040

NOTE: YOU SHOULD MAKE A COPY OF YOUR COMPLETED CLAIM FORM, EOBS, RECEIPTS, AND ITEMIZED BILLS FOR YOUR RECORDS.

	Date Received:	Amount Approved This Claim:	Amount Denied This Claim:	Date Processed:	Processed By:	Benefits Paid To Date:
For Office Use Only						