

Submit or view claims ONLINE: <https://benefits.paychex.com>

Paychex Employee Services: 877-244-1771, automated system available 24/7, Representatives available Monday – Friday 8:00 a.m. – 8:00 p.m. ET

Docket # _____



**Paychex Benefit Account (PBA) Reimbursement Claim
Unreimbursed Medical Expenses**

EMPLOYEE INFORMATION (print)

Employee Name _____ Company Name _____
 Social Security Number (last 4 digits) _____ Employee Telephone Number (____) _____ - _____
 Email Address _____

**** PLEASE DO NOT USE THIS FORM TO SUBMIT DEBIT CARD SUBSTANTIATION ****

Visit <https://benefits.paychex.com> at any time to submit claims ONLINE or learn the status of your claim.

All claim reimbursements will be processed within 2 business days upon receipt of the completed claim form and all supporting documentation.

INSTRUCTIONS CHECKLIST:

- Enclose copies of all itemized bills; receipts, or Explanation of Benefits (EOB) from your provider or a copy of your orthodontia services contract, if applicable. **We recommend using the FSA Orthodontia Claim Form (FSA045) to submit for Orthodontia services.** Use blue or black ink only to identify FSA items on receipts. Do not use highlighter. **Copies of personal checks, cancelled checks, or credit card receipts are not valid for verification of service.**
- Verify that bills and receipts contain:
 - date of service
 - description of service
 - cost of service
 - provider's name
 - provider's address

**** OVER THE COUNTER MEDICATIONS WILL REQUIRE A PRESCRIPTION FROM YOUR DOCTOR ****

- If you are currently funding a Health Savings Account (HSA) in addition to your FSA, your FSA is a limited purpose FSA and may only be used to pay for vision, dental, and preventative medical expenses.
- Sign your claim form** and fax it to the number noted above. Retain a copy for your records.
- If you prefer, mail your claim to: Paychex, Inc., FSA Claims, PO Box 3000, Henrietta, NY 14467-3000.

Name of Service Recipient*	Relationship to Employee	Service Date(s)	Service Description	Service Provider	Amount
Sample John Doe	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Dependent	07/07/07	<input checked="" type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Pharmacy	Dr. Jones	\$521.43
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Pharmacy		\$
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Pharmacy		\$
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Pharmacy		\$
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Pharmacy		\$
TOTAL					\$

If you have more claims, please complete additional Reimbursement Claim forms.

*All Dependents must be entered online prior to claims submission at <https://benefits.paychex.com>. Click **Add Dependent** from the Profile Section under Paychex Benefit Account.

CLAIM INFORMATION

I certify that the information here is true and correct; that the expenses incurred were for myself, my spouse as defined by federal law, or my eligible dependents; and that these expenses are not reimbursable under any other health plan coverage.

Employee Signature _____ Date _____ / _____ / _____