

SISC Flex

SmartFlex Card and/or Health Care Claim Form



If you have used your SmartFlex card at Medco mail-order, you do not need to complete this form. Your purchases are automatically substantiated.

Employee Name: _____ Social Security #: _____

E-mail Address: _____ School District: _____

Payment Method:

SmartFlex Card (Verification of expense deducted from my SISC Health FSA account.) Total Amount \$ _____
▶ *SmartFlex Card documentation must be received by the SISC Flex office within 30 days after purchase or card privileges will be suspended.*

Other Method (Request reimbursement for out-of-pocket expenses) Total Amount \$ _____
▶ *On each receipt, please circle the items that you are claiming.*

Employee's Certification: *I certify that the attached expenses were incurred by me (and/or my spouse and/or eligible dependents), and were not reimbursed by any other plan. To the best of my knowledge and belief, request for repayment of out-of-pocket expenses are eligible for reimbursement under my SISC Health FSA plan. I (or we) will not use the expense claimed through this account as deductions or credits when filing my (our) individual income tax return. Further, I understand I may submit claims for reimbursement for 90 days after the end of the Plan Year. Claims and supporting documentation must be received by the SISC office no later than March 31st.*

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ Date: _____

REMEMBER TO INCLUDE SUPPORTING DOCUMENTATION WITH YOUR CLAIM

For **prescription drugs**, attach a legible receipt from the service provider, which includes the date the prescription was purchased, the drug name or prescription number, the amount of purchase, and the name and address of the pharmacy. The Rx ticket typically contains this information. Handwritten information is not acceptable.

For **medical, dental and optical expenses**, documentation must include a legible copy of the provider's itemized statement of the charges, including the date of service, the name of the patient, the provider's name and address, a description of the services rendered, the charges for the service and the co-payment if applicable, and amount paid or expected to be paid by insurance. A copy of the Explanation of Benefits form is also acceptable.

For **over-the-counter medications**, purchases must be clearly defined on the receipt. The IRS ruling states that employees seeking reimbursement for nonprescription medications **must** present a receipt of purchase indicating the *date of purchase*, the *amount* and the *name of the product*. If the item you are claiming is abbreviated on your receipt, you must attach a photocopy of the package label showing the full product description. We are unable to approve any item that is submitted with insufficient documentation. **When using your SmartFlex card, purchase your qualified over-the-counter medications separately from ineligible expenses.** Refer to our website for a listing of eligible over-the-counter expenses.
<http://wwwstatic.kern.org/gems/siscFlex/EligMedDCAPandOTCexpenses090.xls>

For SISC Use Only

Authorization _____ Date _____ SF Approved _____ SF Pending _____ SF Denied _____

Reimbursement Approved _____ Reimbursement Denied _____ Claim # _____

Explanation: _____

Mail Claim Form and Supporting Documentation to:
SISC Flex
P.O. Box 1808, Bakersfield CA 93303-1808
Or Fax to (661) 636-4063