Offset Claim Form-Flexible Spending Account (FSA) & Health Reimbursement Account (HRA)

Instructions For Quick Processing:

- Fully complete & sign this claim form
- Attach copies of supporting EOB, receipts, vouchers, bills, etc.
- All receipts must detail each of the items summarized below
- Please list one expense per line
- Please print when using this form
- Please allow 2 business days for claims to be processed

For Account Balance:
Go to my.nbsbenefits.com
or call (855) 399-3035

1 Personal Information

Employee Name (First Name, Last Name) _____ Company Name _____

Street Address _____ City _____ State _____ Zip Code _____ ☐No ☐Yes Address Change?

Phone Number _____ Social Security Number _____

2 FSA Expenses – please use the items below to offset my balance due amount

	Date of Service MM	DD	YY	Medical	Rx	Dental	Vision	Hospital	Ortho dontia	Other Services: Please Specify	Person Receiving Service	Amount
1				☐	☐	☐	☐	☐	☐			
2				☐	☐	☐	☐	☐	☐			
3				☐	☐	☐	☐	☐	☐			
4				☐	☐	☐	☐	☐	☐			

Total FSA Health Expenses _____

3 HRA Expenses – please use the expenses below to offset my balance due amount

	Date of Service MM	DD	YY	Provider	Service Rendered	Person Receiving Service	Amount
1							
2							
3							
4							

Total HRA Expenses _____

4 Employee Signature

I, the undersigned, attest that to the best of my knowledge these statements are complete and true. I authorize the release of any medical information to my spouse. I certify these expenses are for valid services provided on the dates indicated and will not be reimbursed or claimed under any other Plan or claimed as a tax deduction.

Employee Signature _____ Date _____

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