

# Flexible Spending Account (FSA) Claim Form



## Instructions For Quick Claim Processing:

- Fully complete & sign this claim form
- Attach copies of supporting EOB, receipts, vouchers, bills, etc.
- All receipts must include a date, description, and amount of the service
- Please list one expense per line
- Please print in dark blue or black ink when using this form
- Please allow 2 business days for claims to be processed

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

## 1 Personal Information

Employee Name	Company Name
Street Address, City, State, Zip	<input type="checkbox"/> No <input type="checkbox"/> Yes Address Change?
Phone Number	Social Security Number

## 2 Dependent Care Expenses (Dates of Service are required in order to process claim)

	Date of Service	Service Provider Tax ID# or SS#	Dependent's Name	Age	Amount
	Start Date	End Date			
1	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____
4	_____	_____	_____	_____	_____
<b>Total Dependent Care Expenses</b>					_____

## 3 Health Care Expenses

	Date of Service			Medical	Rx	Dental	Vision	Hospital	Ortho dontia	Other Services: Please Specify	Person Receiving Service	Amount
	MM	DD	YY									
1	__	__	__	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
2	__	__	__	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
3	__	__	__	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
4	__	__	__	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
5	__	__	__	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
6	__	__	__	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
7	__	__	__	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
8	__	__	__	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
9	__	__	__	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
<b>Total Health Care Expenses</b>											_____	

## 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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**Please fax, mail, or email your claim form and receipts to the following:**  
**Mail:** National Benefit Services, LLC, P.O. Box 219393, Kansas City, MO 64121-9393  
**Email:** [service@nbsbenefits.com](mailto:service@nbsbenefits.com) (PDF, TIFF, or JPG files only)